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2020 FEB 18 AM 8:29
WV PURCHASING DIVISION

TITLE PAGE

RFP Subject: Mountain Health Trust (MHT) Managed Care

Number: CRFP 0511 BMS2000000002

Vendor's Name: Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia

Business Address: 500 Virginia Street East, Suite 400, Charleston, WV 25301

Telephone Number: 304-348-2041

Fax Number: 959-282-1026

Name of Contact Person: Todd White

Email Address: twhite@aetna.com

Vendor Signature: _____

Date: Jan 27, 2020

DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

David McNichols, Chief Executive Officer, Aetna Medicaid
(Name, Title)

[signature] Chief Executive Officer
(Printed Name and Title)

3600 Mansell Road, 4th Floor, Alpharetta, GA 30022
(Address)

770-346-1045 / 860-273-6939
(Phone Number)/ (Fax Number)

McNicholsD@aetna.com
(email address)

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia
(Company)

[signature] Chief Executive Officer and President
(Authorized Signature) (Representative Name, Title)

David J. McNichols, Chief Executive Officer and President
(Printed Name and Title of Authorized Representative)

01/27/2020
(Date)

770-346-1045 / 860-273-6939
(Phone Number) (Fax Number)

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6.8 Availability of Information

Proposal submissions become public and are available for review after opening pursuant to West Virginia Code §5A-3-11(h) (http://www.wvlegislature.gov/wvcode/code.cfm?chap=05a&art=3). All other information associated with the RFP, including but not limited to, technical scores and reasons for disqualification, will not be available until after the contract has been awarded pursuant to West Virginia Code of State Rules §148-1-6.3.d (https://www.state.wv.us/admin/purchase/rule_148-01.pdf).

By signing below, I certify that I have reviewed this Request for Proposal in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that, to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia
(Company)

[signature], Chief Executive Officer and President
(Representative Name, Title)

770-346-1045 / 860-273-6939
(Contact Phone/Fax Number)

01/27/2020
(Date)

Purchasing Divison
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604
Doc Description: RFP for Mountain Health Trust (MHT) Managed Care
Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-17	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	1

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301
(304) 348-2041

FOR INFORMATION CONTACT THE BUYER

April E Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X FEIN # 55-0712129 **DATE** 1/28/2020

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

The West Virginia Purchasing Division is soliciting proposals on behalf of the West Virginia Department of Health and Human Resources to provide statewide physical and behavioral health managed care services to individuals enrolled in West Virginia's Medicaid Managed Care Programs, including the program currently designated as the "Mountain Health Trust" (MHT).

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2023

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861	PROCUREMENT OFFICER - 304-356-4861
HEALTH AND HUMAN RESOURCES	HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES	BUREAU FOR MEDICAL SERVICES
350 CAPITOL ST, RM 251	350 CAPITOL ST, RM 251
CHARLESTON WV25301-3709	CHARLESTON WV 25301-3709
US	US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFP 0511 BMS2000000002
Addendum Number: 1

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[X] Correction of error

[ ] Other

Description of Modification to Solicitation:

To clarify the location, date, and time of the mandatory pre-bid meeting.

THE MANDATORY PRE-BID MEETING WILL BE HELD AT:

ONE DAVIS SQUARE
SUITE 100E, CR134
CHARLESTON WV 25301

ON JANUARY 8, 2020, AT 10:00 AM EST

No other changes.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda

may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP 0511 BMS2000000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

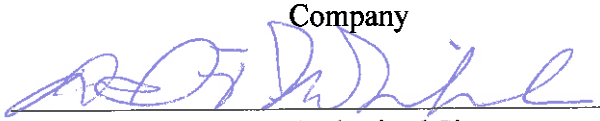
Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓]	Addendum No. 1	[ ]	Addendum No. 6
[ ]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[ ]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Coventry Health Care of West Virginia, Inc.
dba Aetna Better Health® of West Virginia
Company



Authorized Signature

1/28/2020
Date

Purchasing Divison
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604

Doc Description: Addendum #1 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-18	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	2

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301
(304) 348-2041

FOR INFORMATION CONTACT THE BUYER

April E Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X **FEIN #** 55-0712129 **DATE** 1/28/2020

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum #1 is issued to clarify the location, date, and time of the mandatory pre-bid meeting.

THE MANDATORY PRE-BID MEETING WILL BE HELD AT:

ONE DAVIS SQUARE
SUITE 100E, CR 134
CHARLESTON WV 25301

ON JANUARY 8, 2020, AT 10:00 AM EST

No other changes.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 EALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2023

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 S	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFP BMS2000000002
Addendum Number: 2

The purpose of this addendum is to modify the solicitation identified as CRFP MCH200000001 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[X] Other

Additional Documentation:

To change the buyer and contact information on the CRFP.

Brittany Ingraham, Senior Buyer, will now be the assigned buyer to the CRFP.
Email: Brittany.E.Ingraham@wv.gov
Phone number: 304-558-0067

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP BMS2000000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

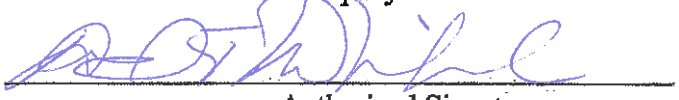
Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[ ]	Addendum No. 1	[ ]	Addendum No. 6
[✓]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[ ]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Coventry Health Care of West Virginia, Inc.
dba Aetna Better Health® of West Virginia
Company



Authorized Signature

1/28/2020
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

Purchasing Divison
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604

Doc Description: Addendum #2 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-23	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	3

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301
(304) 348-2041

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X _____ **FEIN #** 55-0712129 **DATE** 1/28/2020

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:
Addendum No. 2 - issued to change the buyer and contact information for the CRFP. Contact Information: Brittany Ingraham, Senior Buyer Email: Brittany.E.Ingraham@wv.gov Phone number: 304-558-0067 No other changes.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2021

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2022

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

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Extended Description :
MHT MCO FY2023

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Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFP BMS2000000002
Addendum Number: 3

The purpose of this addendum is to modify the solicitation identified as CRFP BMS2000000002 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[X] Other

Additional Documentation:

1. This addendum is issued to correct the documentation previously provided on Addendum No. 2 since the wrong solicitation number was listed at the top of the page.

2. Buyer and contact information on the CRFP.

   Brittany Ingraham, Senior Buyer, will now be the assigned buyer to the CRFP.
   Email: Brittany.E.Ingraham@wv.gov
   Phone number: 304-558-0067

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP BMS2000000002

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Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

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(Check the box next to each addendum received)

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[✓]	Addendum No. 3	[ ]	Addendum No. 8
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Coventry Health Care of West Virginia, Inc.
dba Aetna Better Health® of West Virginia
Company

Authorized Signature

1/28/2020
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

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Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604

Doc Description: Addendum #3 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-23	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	4

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301
(304) 348-2041

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X FEIN # 55-0712129 DATE 1/28/2020

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum No. 3 - issued to correct attached documentation previously provided on Addendum No. 2 since the wrong solicitation number was listed at the top of the page.

Buyer Contact Information:
Brittany Ingraham, Senior Buyer
Email: Brittany.E.Ingraham@wv.gov
Phone number: 304-558-0067

No other changes.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2021

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2022

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 EALTH AND HUMAN RESOURCES UREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2023

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 S	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFP BMS2000000002
Addendum Number: 4

The purpose of this addendum is to modify the solicitation identified as CRFP BMS2000000002 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[X] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[ ] Other

Description of Modification to Solicitation:

To provide the pre-bid meeting sign-in sheets.

No other changes.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP BMS2000000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[ ]	Addendum No. 1	[ ]	Addendum No. 6
[ ]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[✓]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Coventry Health Care of West Virginia, Inc.
dba Aetna Better Health® of West Virginia
Company

Authorized Signature

1/28/2020
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

Purchasing Divison
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604

Doc Description: Addendum #4 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2020-01-08	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	5

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301
(304) 348-2041

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X _____ **FEIN #** 55-0712129 **DATE** 1/28/2020

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum No. 4 - issued to provide the pre-bid meeting sign-in sheets.

No other changes.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023				

Comm Code	Manufacturer	Specification	Model #
80000000			

Extended Description :
MHT MCO FY2023

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFP 0511 BMS2000000002
Addendum Number: 5

The purpose of this addendum is to modify the solicitation identified as CRFP 0511 BMS2000000002 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[X] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[X] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[X] Other

Additional Documentation: This purpose of this addendum is to:

1. Modify the bid opening date as follows:

   Bid opening WAS 02/12/2020 at 1:30 PM ET
   Bid opening IS NOW 02/18/2020 at 1:30 PM ET

2. Provide a Change Log
3. Provide Vendor Questions and Agency Responses
4. Attach Appendix 7_SFY21 Service Provider Agreement
5. Attach Appendix 8_CHIP Provider Listing

No other changes.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP 0511 BMS2000000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[X]	Addendum No. 1	[ ]	Addendum No. 6
[X]	Addendum No. 2	[ ]	Addendum No. 7
[X]	Addendum No. 3	[ ]	Addendum No. 8
[X]	Addendum No. 4	[ ]	Addendum No. 9
[X]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Coventry Health Care of West Virginia, Inc.
dba Aetna Better Health® of West Virginia
Company

Authorized Signature

February 10, 2020
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604

Doc Description: Addendum #5 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2020-02-05	2020-02-18 13:30:00	CRFP 0511 BMS2000000002	6

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301
(304) 348-2041

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X [signature] **FEIN #** 55-0712129 **DATE** Feb 10, 2020

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum No. 5 - The purpose of this addendum is to:

1. Modify the bid opening date as follows:

Bid opening WAS 02/12/2020 at 1:30 PM ET
Bid opening IS NOW 02/18/2020 at 1:30 PM ET

2. Provide a Change Log
3. Provide Vendor Questions and Agency Responses
4. Attach Appendix 7_SFY21 Service Provider Agreement
5. Attach Appendix 8_CHIP Provider Listing

No other changes.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2023

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

SOLICITATION NUMBER: CRFP 0511 BMS2000000002
Addendum Number: 6

The purpose of this addendum is to modify the solicitation identified as CRFP 0511 BMS2000000002 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[X] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[ ] Other

Additional Documentation: This purpose of this addendum is to:

1. Provide Agency responses to additional Vendor questions.

Bid Opening will remain 02/18/2020 at 1:30 PM ET

No other changes.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

CRFP 0511 BMS2000000002
Agency responses to additional Vendor questions

1.) Is it the State's intent that Attachment 4: Project Organization and Staffing Approach (25 pages) and Attachment 5: Mandatory Requirements (10 pages) be double-spaced? We want to ensure we have interpreted this correctly and all bidders will be held to this requirement under the same page limits.

Answer: Yes, this is the State's intent. However, as noted in prior responses, this requirement is not applicable to resumes and bulleted lists which may be single spaced.

2.) Can the state confirm that required supplemental documentation previously excluded from page counts (organizational charts, resumes, forms, descriptions of roles associated with organizational charts) do not count towards applicable page counts?

Answer: Attachments should correspond to the page limits defined by the applicable section. The vendor is permitted 2 pages per resume, as outlined within Attachment 4. Please note that no documents referenced within Appendix 4 is due at time of bid, and thus should not impact page availability. For any plans requested as part of the specifications, the vendor may provide narrative describing their plans, should the plan itself exceed the allotted number of pages.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP 0511 BMS2000000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[X]	Addendum No. 1	[X]	Addendum No. 6
[X]	Addendum No. 2	[ ]	Addendum No. 7
[X]	Addendum No. 3	[ ]	Addendum No. 8
[X]	Addendum No. 4	[ ]	Addendum No. 9
[X]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Coventry Health Care of West Virginia, Inc.
dba Aetna Better Health® of West Virginia

Company

David Delany

Authorized Signature

2/13/2020

Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

Purchasing Divison
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604

Doc Description: Addendum #6 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2020-02-07	2020-02-18 13:30:00	CRFP 0511 BMS2000000002	7

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301
(304) 348-2041

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X [signature] **FEIN #** 55-0712129 **DATE** 2/13/2020

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:
Addendum No. 6 - The purpose of this addendum is to:

1. Provide Agency responses to additional Vendor questions.

Bid Opening will remain 02/18/2020 at 1:30 PM ET

No other changes.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021	0.00000			

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2021

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022	0.00000			

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2022

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023	0.00000			

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2023

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024	0.00000			

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

ATTACHMENT 3: VENDOR QUALIFICATIONS & EXPERIENCE

1. Organization Overview

This section of the Vendor's Technical Proposal should include an overview of the Vendor and any subcontractor(s), excluding direct-care providers. The Vendor should provide their response as part of their bid in accordance with the template(s) below. Unless otherwise stated, requested documentation must be provided to the Department as part of the bid submission.

1.1 Vendor Overview

Provide all relevant information regarding the general profile of the Vendor. The Vendor should provide their response as part of their bid in accordance with the template below.

The Vendor is NOT to change any of the pre-filled cells in the following tables.

Table 5: Vendor Overview[1]

Vendor Overview	
Corporate (Legal) Name	Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia (Aetna Better Health of West Virginia)
Name of Parent Company (If Applicable)	Aetna Health Holdings, LLC is Aetna Better Health of West Virginia's direct parent. Aetna Inc. and CVS Pharmacy, Inc. are indirect parents of Aetna Better Health of West Virginia. CVS Health Corporation (CVS Health) is Aetna Better Health of West Virginia's ultimate parent.
Tax Identification Number	55-0712129
Industry (North American Industry Classification System [NAICS])	NAIC# 95408
Type of Legal Entity	For-profit corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Aetna Better Health of West Virginia's direct parent, Aetna Health Holdings, LLC, is a private company, as are two of its indirect parents, Aetna Inc. and CVS Pharmacy, Inc. Aetna Better Health of West Virginia's ultimate parent, CVS Health Corporation, is a publicly traded company.
Number of Full-Time Employees	Aetna Better Health of West Virginia has approximately 247 full-time staff, as of January 2020. (This total includes staff for both Mountain Health Trust and Mountain Health Promise).

[1] Aetna Better Health of West Virginia is a dba for Coventry Health Care of West Virginia, Inc. and is used for Coventry Health Care of West Virginia, Inc.'s Medicaid line of business. Separate from its Medicaid line of business, Coventry Health Care of West Virginia, Inc. also conducts Medicare business. Unless otherwise indicated, the responses in Table 5, Vendor Overview, pertain to Aetna Better Health of West Virginia's Medicaid line of business. If the Department seeks information about Coventry Health Care of West Virginia, Inc.'s Medicare business, we will provide it upon request.

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

Vendor Overview	
Last Fiscal Year Company Revenue	Aetna Better Health of West Virginia's last fiscal year company revenue was $561,337,096 (2018).
Last Fiscal Year Company Net Income	Aetna Better Health of West Virginia's last fiscal year company net income was $17,218,971 (2018).
% of Revenue From State Government Clients in the United States	100% of Aetna Better Health of West Virginia's revenue is from state government clients.
Number of Years in Business	23 years[2]
Number of Years Vendor Has Been Providing the Type of Services Specified in the RFP	Aetna Better Health of West Virginia has been providing Medicaid services of the type specified in the RFP since 1996. The Aetna Medicaid organization has been administering Medicaid services for over 30 years.
Number of Employees Providing the Type of Services Specified in the RFP	Aetna Better Health of West Virginia has approximately 247 full-time staff, as of January 2020. (This total includes staff for both Mountain Health Trust and Mountain Health Promise).
Headquarters in the United States	Aetna Better Health of West Virginia is located in Charleston, West Virginia, United States. The headquarters of its ultimate owner, CVS Health Corporation, is in Woonsocket, Rhode Island, United States.
Headquarters Mailing Address	500 Virginia Street East, Suite 400 Charleston, WV 25301
Street Address	500 Virginia Street East, Suite 400 Charleston, WV 25301
Telephone Number	304-348-2041
Fax Number	959-282-1026
Locations in the United States	Aetna Better Health of West Virginia is located in Charleston, West Virginia.
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** Aetna Better Health of West Virginia **Mailing Address:** 500 Virginia Street East, Suite 400, Charleston, WV 25301 **Street Address:** 500 Virginia Street East, Suite 400, Charleston, WV 25301 **Telephone Number:** 304-348-2041 **Fax Number:** 959-282-1026

[2] Aetna Better Health of West Virginia is the dba used by Coventry Health Care of West Virginia, Inc. for its Medicaid line of business. Coventry Health Care of West Virginia, Inc., formerly known as Carelink Health Plans, Inc., has been serving West Virginia's Medicaid population since 1996 and was previously a subsidiary of Coventry Health Care, Inc. (Coventry). In May of 2013, Coventry and all its subsidiaries were acquired by Aetna Inc. On January 1, 2014, Coventry was merged into Aetna Health Holdings LLC. In December of 2015, Coventry Health Care of West Virginia, Inc. began using the dba Aetna Better Health of West Virginia for its Medicaid line of business.

REQUEST FOR PROPOSAL

Department for Health and Human Resources

CRFP 0511 BMS2000000002

Vendor Overview	
Name of Contact Person for Bid	Todd White, Chief Executive Officer

The Vendor should provide a list of all counties for which the Vendor intends to serve members, and indicate whether the Vendor has received approval from the Department of Insurance to serve Medicaid and WV CHIP members in each county. *All counties must be served under the contract resulting from this solicitation.*

Counties to be Served

Aetna Better Health of West Virginia has approval from the Department of Insurance and currently serves Medicaid members in all 55 West Virginia counties. We intend to continue to serve members in all 55 West Virginia counties.

- The Vendor should describe the business type of the Vendor and its parent company, as applicable.

Business Type of the Vendor and Its Parent Company

Aetna Better Health of West Virginia is a for-profit corporation. Aetna Better Health of West Virginia is wholly owned by Aetna Health Holdings, LLC, a for-profit limited liability company. Aetna Health Holdings, LLC is a wholly owned subsidiary of Aetna Inc., a for-profit corporation. Aetna Inc. is a wholly owned subsidiary of CVS Pharmacy Inc., also a for-profit corporation. CVS Pharmacy Inc. is wholly owned by CVS Health Corporation, a for-profit, publicly traded company. **Figure 3.1.1-1** depicts the relationship between Aetna Better Health of West Virginia and its parent entities.

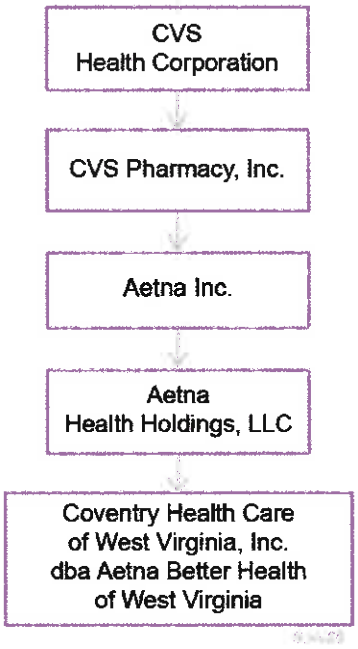


Figure 3.1.1-1: Aetna Better Health of West Virginia's Relationship to its Parent Entities
Aetna Better Health of West Virginia is a local health plan supported by national resources.

- The Vendor should provide the number of current Medicaid and CHIP members in other states, by state, and describe any experience managing services for members in other Medicaid programs or other lines of business within West Virginia.

With more than 23 years serving as a committed partner to the people of West Virginia and the Department of Health and Human Resource (Department), Aetna Better Health of West Virginia has a deep understanding, years of experience and a proven, longstanding history of providing innovative solutions that improve health outcomes for West Virginia's Medicaid population. Since 1996, we have had the honor and privilege of providing access to care through the delivery of comprehensive services supporting the program's goals and full scope of work. Every day, our entire team—both locally and nationally—is focused on fostering robust relationships, collaborations, and alignment with each of our system partners to provide our members with needed supports and services in the most integrated, appropriate, and cost-effective way possible. Our member obsessed approach to helping our members achieve their health ambitions means we are with our members every step of the way.

This commitment is reflected in Aetna Better Health of West Virginia's many successful outcomes and the ongoing innovations that allow us to inspire and optimize performance and service.

Aetna Better Health of West Virginia's Medicaid Experience

We have had the privilege of serving the West Virginia's Mountain Health Trust populations since 1996 and the West Virginia Health Bridge Medicaid expansion population since 2015 and we were recently honored to be awarded Mountain Health Promise. We currently serve more than 137,000 West Virginia Medicaid beneficiaries and will serve approximately 18,000 Mountain Health Promise members across all 55 counties once implemented in the first quarter of 2020. The Aetna Medicaid organization's established presence in the state as an original Medicaid managed care organization provides us with important insights and depth regarding the unique needs of our members and providers across all regions of the State. As a long-term, committed partner of the Department, Aetna Better Health of West Virginia has the structure and resources, a proven whole-person approach, and the innovative and collaborative drive to deliver high-quality, cost-effective health care services to West Virginia's Medicaid and Children's Health Insurance Program (CHIP) beneficiaries.

Demonstrated History of Success

Aetna Better Health of West of Virginia has a demonstrated history of supporting the Department in achieving its program goals and improving the health and lives of West Virginians. We have maintained 'Commendable' status from the National Committee for Quality Assurance (NCQA) without interruption since 2016. Additionally, for three of the last four years, we have earned 100% in all areas—grievance and appeals, Healthcare Effectiveness Data and Information Set (HEDIS) performance measure validation, and performance improvement plans—of the External Quality Review Organization (EQRO) reviews, with a score of 99% in 2017.

Our in-depth understanding and established local presence in communities throughout the State informs our organizational framework to provide integrated, person-centered services—to develop and maintain a high-quality, accessible provider network and develop innovative approaches to

achieve improved health outcomes, enhance quality, reduce fragmentation, and offer seamless continuity of care. Under the leadership of Chief Executive Officer Todd White, a proud, lifelong West Virginian from the Charleston area, Aetna's experienced team has a deep understanding of the critical health issues and members' needs in the State. Chief Financial Officer Tina Bailes has more than 20 years of experience in health care, including 17 years with the West Virginia Bureau for Medical Services in progressive positions, including serving as the Deputy Commissioner of Finance and Administration. Compliance Officer Alva "Fuzzy" Page III, Esq. has more than 15 years of health care experience, including six years serving as general counsel for the West Virginia Bureau for Medical Services and six years serving as a West Virginia Assistant Attorney General.

As a leader in innovation, we continually strive to identify and develop new approaches to improve health outcomes for West Virginia's Medicaid and CHIP members. Aetna Better Health of West Virginia's deep understanding of West Virginia uniquely allows us to customize national models to the specific geographic and cultural needs through the state. For example, we are customizing the Family First program, a national model, to meet the challenges and needs that are specific to West Virginia's Mountain Health Promise members and families. A few examples of new innovations we continue to develop and implement for the Mountain Health Trust and West Virginia CHIP populations include the following:

- System of care (SOC) model: Our SOC model assess factors that negatively impact health and addresses them through a comprehensive array of supports and services. Aetna's integrated approach is inclusive of physical health, behavioral health, oral health, health literacy, and functional needs, as well as social needs such as housing, employment, healthy food, and transportation. Our SOC is based on the principles of trauma-informed care, culturally and linguistically appropriate services, and recovery.

- Regionally based Care Connection teams (CCTs): We understand the impact geographic and regional differences have on our West Virginia members, and have established regional Care Connection Teams who live in, know, and understand the communities in which they work. Additionally, we pair our members with care coordinators whose expertise, credentials, and training are aligned to the clinical and social needs of the member. We have developed comprehensive regional and statewide initiatives and programs to address key health disparities West Virginians face such as the following:
  - Neonatal abstinence syndrome (NAS) program: Our NAS care management program focuses on providing supports to keep moms engaged in treatment and increase the number of babies staying with their moms. **In 2019, 87 percent of mothers in our NAS care management program stayed in opioid treatment and/or counseling during pregnancy and for the first year after delivery.**
  - Diabetes management program: Aetna's diabetes management program seeks to assist members with a diagnosis of diabetes and their supports to understand the health risks of living with diabetes, as well as the benefits of adhering to blood glucose testing and prescribed treatment regimens. The program elicits changes in members' behaviors, positively impacting their current and future health and wellness.
  - Social determinants of health (SDOH): We have implemented a closed loop referral system to connect members to services that address SDOH needs. This closed loop system, coupled with the CCTs' intimate knowledge of regional needs, allows us to provide appropriate and timely referrals that reduce SDOH-related barriers in accessing care.

Impact of Local Care

Our regional Care Connection teams provide highly effective services because they live and know the communities in which they work. The impact of our local approach to care is demonstrated by the following outcomes:

- Increased face-to-face visits 300%
- Decreased opt-out rate 41%
- Reduced readmissions 14%
- Reduced emergency room visits 7%

- Strategic collaborations: Aetna Better Health of West Virginia has also worked to develop key programmatic partnerships with federally qualified health centers such as Williamson Health and Wellness to offer co-located care management in collaboration with their community health workers. Additionally, we have longstanding relationships with many community-based organizations, such as West Virginia's two food banks, Facing Hunger and Mountaineer Food Banks, including providing $13,000 to the two food banks during the 2018 teacher's strike to provide students with access to quality food during school closures and purchasing a box truck for the Mountaineer Food Bank to help with their mobile food pantry events.

Aetna Better Health of West Virginia understands that each population has unique service needs, and our local, member-devoted approach focuses on our individual members' holistic health needs. We are fully committed to collaborating with the Department and other West Virginia agencies, members,

providers, and community-based organizations, and we are excited to leverage our local and national experience to provide individualized, quality care and exceptional customer service for members and providers.

Aetna's National Medicaid and CHIP Experience

With over 30 years of experience serving Medicaid members, the Aetna Medicaid organization possesses the expertise necessary to provide a quality-driven, health care delivery model that directly aligns with the Department's objectives. Aetna has a long history of responding to the holistic needs of our members by expanding our focus to go beyond the delivery of physical health care services to include coordinated, team-based approaches to care delivery, promote community-based public health initiatives, mitigate SDOH, and increase access to needed services for underserved populations and rural communities. Our health plans are always locally based and supported by national resources as we continuously seek new and innovative ways to serve the most vulnerable individuals in their communities with quality benefits, services, and improved outcomes.

Aetna's Medicaid and CHIP Members Served by State

In addition to our 23 years of locally based experience in West Virginia, Aetna's national Medicaid organization currently serves approximately 2.3 million people in 16 states, including nearly 145,000 CHIP members in 12 states. Our extensive Medicaid managed care experience is summarized in **Table 3.1.1-1**, and includes serving the full spectrum of Medicaid populations, including Aged Blind Disabled/Social Security Income (ABD/SSI), Affordable Care Act (ACA) adults, behavioral health (BH), Children's Health Insurance Program (CHIP), children with special health care needs (CSHCN), dually-eligible individuals (Duals), intellectually/developmentally disabled (I/DD), long-term services

and supports (LTSS), serious mental illness (SMI), and Temporary Assistance for Needy Families (TANF) populations.

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Table 3.1.1-1: Aetna's Medicaid Managed Care Experience Nationwide

State Approx. 2019 Year End Enrollment	Years	ABD /SSI	ACA Adults	BH Carve-in	CHIP	CSHCN	Duals	Foster Care	I/DD (for acute)	LTSS	SMI	TANF
AZ[3] Medicaid: 375,100 CHIP: 8,500	17	●	●	●	●		●	●	●	●	●	●
CA Medicaid: 13,250 CHIP: 6,300	1	●	●	●	●		●			●		●
FL Medicaid: 94,500 CHIP: 97,700[4]	25	●		●	●		●		●	●		●
IL[5] Medicaid: 348,600	7	●	●	●			●			●	●	●
KS Medicaid: 92,250 CHIP: 11,000	1	●		●	●	●	●	●	●	●	●	●

[3] Aetna's Medicaid managed care experience in Arizona is through Mercy Care, which is not a subsidiary of Aetna Inc. but is managed by Aetna's Medicaid organization.
[4] The Florida enrollment includes new members served under a new contract that was effective on January 1, 2020.
[5] On January 23, 2020 CVS Health acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare) located in Illinois. Membership numbers for Illinois include IlliniCare membership for Medicaid populations.

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State Approx. 2019 Year End Enrollment	Years	ABD /SSI	ACA Adults	BH Carve-in	CHIP	CSHCN	Duals	Foster Care	I/DD (for acute)	LTSS	SMI	TANF
KY Medicaid: 207,000 CHIP: 9,800	8	●	●	●	●	●		●			●	●
LA Medicaid: 119,900 CHIP: 130	3	●	●	●	●	●	●	●	●		●	●
MD Medicaid: 26,275 CHIP: 1,700	2	●	●		●	●		●				●
MI[6] Medicaid: 47,600 CHIP: 70	14	●	●	●	●	●	●	●		●	●	●
NJ Medicaid: 58,800 CHIP: 7,000	4	●	●	●	●	●	●	●	●	●	●	●
NY Medicaid: 8,200	6						●			●		

[6] 7,600 of the Medicaid members are Dual MMP

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State Approx. 2019 Year End Enrollment	Years	ABD /SSI	ACA Adults	BH Carve-in	CHIP	CSHCN	Duals	Foster Care	I/DD (for acute)	LTSS	SMI	TANF
OH[7] Medicaid: 25,500	4			•			•			•	•	
PA Medicaid: 201,000 CHIP: 21,200	25	•	•	•	•	•		•			•	•
TX[8] Medicaid: 226,400 CHIP: 33,200	20	•		•	•	•	•		•	•[9]	•	•
VA Medicaid: 156,900 CHIP: 7,200	22	•	•	•	•	•	•	•	•	•	•	•
WV Medicaid: 138,100	23	•	•	•		•		•[10]				•

[7] Dual MMP
[8] Aetna's Medicaid managed care experience in Texas is both through an Aetna affiliated health plan and an unaffiliated health plan administered by Aetna.
[9] Aetna Better Health® of Texas Inc., our affiliate plan, was recently awarded the STAR+PLUS, LTSS contract scheduled to go live third quarter 2020.
[10] Aetna Better Health of West Virginia was recently awarded the Mountain Health Promise contract, which is scheduled to go live first quarter 2020.

Aetna's National Experience Managing Services for Members in Medicaid and CHIP Programs

Over the years, we have contributed to, learned from, and helped to shape the evolution of programs in West Virginia and across the country. Our fully integrated, person-centered, and holistic approach guides our decision-making, informs our policies and culture, and fosters our ongoing relationships with State agencies, providers, community partners, and members and their families to align economic incentives with quality outcomes. We have national experience in implementing, managing, and caring for populations similar to those served by the West Virginia Medicaid and CHIP programs. Our programs focus on member wellness, prevention, acute care, and chronic care needs results in improved access to culturally competent care, higher quality care, and a simplified member experience. Aetna is creating innovative ways to work with providers to deliver greater value to patients. Instead of concentrating solely on treating people when they are sick, we place a greater emphasis on keeping them healthy. In pursuit of this ambition, Aetna partners with provider organizations to improve health outcomes, decrease care costs, and provide a more streamlined member experience. In addition, we address social determinants of health in communities to help our members achieve their health goals. Through continual innovation, openness, and collaboration, we help to transform the health care system by taking a holistic approach to health and well-being.

Aetna health plans in other Appalachian states such as Kentucky, Ohio, Pennsylvania, and Virginia face some of the same unique challenges experienced by West Virginia, including living in large rural areas with transportation and provider access challenges, as well as mitigating the effects of the opioid epidemic. For example, Aetna has developed a multifaceted strategy for combating the complex issue of opioid use disorder (OUD) that emphasizes care coordination and continuity of care by reducing barriers that restrict access to medication-assisted treatment, support programs, and non-

pharmaceutical alternatives. We created an innovative opioid dashboard, which uses pharmacy and medical claims data to trend key metrics to help us combat inappropriate use of opioids. Data from our opioid dashboard demonstrate our success across all Medicaid plans. **Between July 2016 and October 2018, the Aetna Medicaid organization increased the rate of non-opioid treatment for chronic pain by 52.9 percent and decreased the rate of opioid prescriptions for members with OUD by 44 percent.**

Aetna's Medicaid organization has also demonstrated long-term success in managing CHIP programs, including serving CHIP members for more than 25 years in both Pennsylvania and Florida. Each health plan has developed localized best-practice initiatives to serve the individualized needs of the members and demonstrated sustained improvements in member health outcomes. To further demonstrate Aetna's experience managing services for Medicaid and CHIP populations, we provide three examples of other states where the proposed solution of similar size and scope has been implemented. These examples include Virginia, New Jersey, and Florida.

Example 1: Virginia

Aetna Better Health of Virginia contracts with Department of Medical Assistance Services to provide Medicaid, CHIP, LTSS, and Dual Eligible Special Needs Plans managed care services to our members. The scope of services includes medical, behavioral health, pharmacy, vision, and non-emergency medical transportation. Populations include pregnant women, infants, children, low-income adults, children/youth with special health care needs, children in foster care and individuals formerly in foster care, and individuals receiving SSI.

Aetna Better Health of Virginia serves its members through a holistic approach that incorporates a coordinated network of physical and behavioral health care providers, as well as community-based organizations. Our integrated care management program and care coordination system facilitates

collaboration among members, practitioners, providers, care coordinators, family members, the member's circle of support, community organizations, and existing case management entities, thus resulting in a seamless system of services. Aetna Better Health of Virginia works to understand each member's readiness to change, individual preferences and goals, and physical and behavioral health care needs. We assess family and community supports, strengths, and any barriers affecting the member's access to care. In doing so, we help each member achieve their goals and optimize their level of self-care and independence. Our fully integrated system of care is specifically designed to manage members with complex needs. Aetna Better Health of Virginia uses analytic methods to identify our most bio-psychosocially complex and vulnerable members for whom we have an opportunity to make a significant difference.

Simply stated, health care occurs beyond the boundaries of clinical care settings. With a community-focused population health approach, Aetna Better Health of Virginia addresses SDOH in a meaningful way by providing locally tailored solutions that integrate community initiatives with the health care delivery system. We assess SDOH by capturing data through multiple mechanisms including health risk assessments, condition-specific assessments, existing care plans, gaps-in-care reports, reports through our health care equity dashboard, predictive modeling, care coordination claims data, provider feedback, community health workers, community and advocate outreach, member surveys, member advocacy committees, and focus groups. Our health care equity dashboard tracks utilization and identifies members who may benefit from additional interventions and education. It also provides inpatient and emergency department usage by gender, age, race, ethnicity, and county. Similarly, providers access real-time admission, discharge, and transfer information for emergency department, inpatient, and outpatient utilization at the individual member level in collaboration with the Commonwealth's Emergency Departments Information Exchange program.

The effectiveness of this integrated, person-centered wholistic approach has helped to achieve improved member health outcomes, while also demonstrating cost-effectiveness for the program. A few examples of outcomes include the following:

- Focus on one- and two-day admissions for inpatient-to-observation combined and experienced a decrease from 67.9 percent in September to 66.5 percent in August
- Pharmacotherapy management of chronic obstructive pulmonary disease exacerbation (PCE) bronchodilator measure is 89.90 percent, which is at the 95th percentile
- The medication management for people with asthma (MMA) measure for people 51-64 years at 65.22 percent compliance is in the 75th percentile
- Persistence of beta blocker treatment after a heart attack (PBH) is at 83.33 percent, which is the 75th percentile
- Statin therapy for patients with diabetes (SPD) statin adherence of 80 percent is at of 78.95 percent, which is the 75th percentile
- Evaluated the utilization of behavioral health services by provider identifying potential overutilization and rectifying the authorization and utilization when appropriate, resulting in a savings $4.5M FY 2019
- SDOH multidisciplinary team that includes registered dietician, employment and housing specialists, peer support specialists, and community health workers
- Deployed community activation efforts including collaboration with CVS Health and trusted community partners to address SDOH such as Feeding America (food insecurity), Health Wagon/RAM (access to care), and Alive RVA/Mental Health of America (behavioral health)
- Attended 307 local events with 134,510 attendees
- Successfully welcoming significant new membership growth in 2019, including 56,000 new ACA Expansion members and 30,000 new TANF/Family Access to Medical Insurance Security members

Example 2: New Jersey

Aetna Better Health of New Jersey's approach employs best practices for integrating the delivery of care for members, including TANF, CHIP, ABD, and LTSS recipients, throughout the entire continuum of care, including acute care, behavioral health treatment, institutional and facility services, and home- and community-based services. The New Jersey Medicaid Family Care program provides a wide range of services including doctor visits, hospital services, prescriptions, tests, vision care, mental health care, dental, nursing home care, and other health care services, depending on the person's eligibility category.

Aetna Better Health of New Jersey supports a collaborative model among state agencies, providers, community-based organizations, and members, as well as strong interdepartmental coordination to optimize communication to address members' needs within the structure of the benefit. Aetna Better Health of New Jersey excels at care management, which is individualized and addresses the whole member in a model that integrates physical health, behavioral health, and social determinants of health. This dedication has contributed to Aetna Better Health of New Jersey achieving improved member outcomes including but not limited to the following:

- Achieving low rates of hospital readmission, averaging between 5 and 8 percent
- Exceeding the state benchmark for home visits (10 percent of members in care management) by achieving 16 percent
- Achieving 91 percent from IPRO and the Division of Medical Assistance and Health Services on the annual Medicaid audit in 2018
- Achieving a score of 49 out 50 possible points on the NCQA onsite review, attaining full NCQA accreditation

Example 3: Florida

For 25 years Aetna Better Health of Florida has served the Florida Healthy Kids Corporation. We remain as passionate and dedicated as we were on day one to providing the coverage, services, and supports needed to benefit the state's school-age children. Our organizational mission to build a healthier world—one person, one community at a time—directly aligns with our approach to care based in a child-centered, family-oriented model that provides comprehensive, quality health care services. As a holistic health partner, we have provided health care services and supports to children in the Florida Healthy Kids program to bridge the health insurance gap among low-income children ages 5 through 18.

We work closely and collaboratively with our provider networks to integrate our innovative solutions in ways that complement their existing technology and health care service delivery goals. Specific offerings include a progressive payment model, innovative data-sharing technology, care

management and care coordination resources, and technical support that work in harmony to assure alignment across the care continuum. Aetna's progressive approach to driving high-quality, positive outcomes gives providers an array of payment arrangements for increasing clinical and financial complexity and sophistication in risk-sharing.

We offer our members in all 67 counties across the state a variety of enhanced benefits and programs at no cost to both subsidized and full-pay members. We chose our enhanced benefits to improve access to care and promote healthy behaviors, fitness, and safety. These benefits address social determinants of health that positively impact outcomes and satisfaction. Our recent achievements in improving the lives of Florida members include, but are not limited to the following:

- Decreased readmissions by 18 percent in 2018-2019
- Decreased emergency room use by 14 percent
- We achieved 86 percent provider satisfaction scores in 2019—the national average score is 66 percent for Medicaid plans
- Achieved 100 percent in our EQRO review
- Achieved a Consumer Assessment of Healthcare Providers and Systems member satisfaction composite score of 4.0 and a Florida Healthy Kids provider satisfaction rate of 92.9 percent, demonstrating our commitment to quality care and the best possible service for our members, their families/circles of support, and our providers
- Provided 18,000 volunteer hours in the first 11 months of 2019 and made significant community contributions to local community organizations and programs

The Aetna Medicaid organization is dedicated to being a collaborative local partner to each of the state agencies we serve. The above are just a few examples of how our local approach, supported with national experience and resources, have had a positive impact on the lives of our members and helped our state partners in achieving their program goals.

Aetna's Experience Implementing Medicaid and CHIP Programs

The Aetna Medicaid organization has a long history of implementing our proposed approach with organizations of similar size and scope to West Virginia in compliance with all federal and state regulations. Aetna has developed and refined its implementation approach and best practices based on three decades of Medicaid managed care experience. This process enables us to serve the needs of members as we work to achieve full compliance and a seamless transition to new regulatory and contractual requirements.

In 30 years, Aetna's national Medicaid organization has never failed a readiness review. We will use this experience and proven work plan process to implement the West Virginia Managed Care program in a timely and compliant manner.

Aetna's National Implementation Resources

Our local health plan expertise is supported by the unparalleled backing of the Aetna Medicaid organization's extensive clinical, operational, and technology implementation experts. Using our proven approach, the Implementation team manages and monitors a timely process that will meet the Department's objectives. A crucial part of our implementation process with every new program implementation is gathering, confirming, and incorporating all federal and state regulatory and technical requirements into our clinical services, administrative operations, transactional platforms, and program management.

The national Aetna Medicaid organization has successfully implemented over 30 Medicaid programs in the past 10 years. Our approach to implementations, which have supported our successful implementations over the past 23 years in West Virginia, includes the following key elements:

- Developing and maintaining strong relationships early and setting up regularly occurring meetings with system stakeholders and state agencies
- Configuring and maintaining health plan data systems to securely share information with providers, community-based organizations, and state agencies
- Holding regular membership feedback forums specifically for stakeholders serving Medicaid and CHIP members

- Continual training for all staff, including those in member services, utilization management, integrated care management, long-term services and supports, pharmacy, and quality on Medicaid program changes, as well as special needs and requirements of the CHIP population and program
- Continuing to train all staff in trauma-informed care and adverse childhood experiences

Aetna Better Health of West Virginia's Implementation Experience

Aetna Better Health of West Virginia's experience in the state, supported by the national resources and expertise of the Aetna Medicaid organization, provides the foundation for our ability to serve the Medicaid and CHIP populations. We have extensive West Virginia experience and understand the state's culture, and we are well-positioned to adapt to meet the unique challenges facing West Virginia today. As an incumbent health plan, Aetna Better Health of West Virginia has an established network of providers and subcontractors with whom we collaborate with a shared commitment to providing the services needed to improve member outcomes. We have good relationships with our providers, who can trust us to provide the training and resources needed to build their capacity to serve the needs of West Virginia's Medicaid and CHIP members. Aetna Better Health of West Virginia is flexible and focused on solutions that work for our communities.

Implementation Success Story

When Aetna commenced implementation of the Mountain Health Promise program in West Virginia in late 2019, we were able to hire more than 90 new staff quickly using a detailed hiring work plan that included posting positions on the Aetna website, LinkedIn, and other electronic venues, West Virginia Nurses Association, community-based organizations, and other national clinical associations. We also offered an enhanced employee referral bonus that generated numerous referrals and conducted a virtual job fair with 108 registrants. We received over 2,330 resumes, screened more than 393 candidates, and conducted more than 286 individual interviews, as well as second and third interviews depending on the position. Aetna completed background checks and hired 95 new employees in less than 2 months.

Aetna Better Health of West Virginia has a proven record of successfully implementing new contracts and expanding our services to new populations. These include the following:

- Welcoming over 21,000 new Medicaid members with three months preparation in July 2019, when another plan exited the West Virginia Medicaid market, which included reviewing

staffing levels, office space, care patterns for the incoming membership, and assessing the provider network. After the transition of the members occurred, we identified several opportunities to improve the utilization and care management activities for the newly transitioned members. Aetna Better Health of West Virginia care management staff engaged in intensive outreach to the new membership to help coordinate needed services to address their complex needs.

- Implementing changes to benefits in support of the State's Medicaid program, including the following:
  - Pharmacy (carved in) in April 2013
  - Children's dental benefit in January 2014
  - Behavioral health benefit in July 2017
  - Pharmacy (carved out) in July 2018
  - Institutions for mental disease in January 2019
  - Substance use disorder in July 2019

Additionally, we are currently in the process of implementing the Mountain Health Promise program, and are honored to work with several state agencies, community-based organizations, and stakeholders, to improve the lives of the approximately 18,000 children and youth who will be served under this new program.

- The Vendor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104):
  - The name and address of any person (individual or corporation) with an ownership or control interest in the Vendor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Individuals and Corporations with Ownership and Control Interest

In **Table 3.1.1-2**, we provide the name and address of any person (individual or corporation) with an ownership or control interest in Aetna Better Health of West Virginia, other than institutional investors with a beneficial ownership of 5 percent or more of CVS Health Corporation's common stock.

Please note that Aetna Better Health of West Virginia's ultimate parent, CVS Health Corporation, is a publicly traded company listed on the New York Stock Exchange and registered with the Securities Exchange Commission (SEC). As a publicly traded company, CVS Health Corporation does not track the identity of individual shareholders but relies on disclosures of beneficial ownership of CVS Health

Corporation stock, which the SEC requires investors to file on Schedules 13D and 13G and related amendments. From time to time, certain institutional investors have filed Schedules 13D and 13G with the SEC, indicating beneficial ownership of 5 percent or more of CVS Health Corporation's common stock. In such filings, the beneficial owner certifies that their shares were acquired in the ordinary course of business and were not acquired for the purpose of changing or influencing the control of CVS Health Corporation.

Table 3.1.1-2: Ownership and Control Interest Information

Name	Address[11]	Tax ID Number (entities)
CVS Health Corporation (Ultimate Owner)	One CVS Drive Woonsocket, RI 02895	05-0494040
CVS Pharmacy, Inc. (Indirect Owner)	One CVS Drive Woonsocket, RI 02895	05-0340626
Aetna Inc. (Indirect Owner)	151 Farmington Drive Hartford, CT 06156	23-2229863
Aetna Health Holdings, LLC (Direct Owner)	151 Farmington Drive Hartford, CT 06156	30-0123754
David McNichols Director, Principal Officer - Chief Executive Officer and President	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A
David P. Delaney Director, Principal Officer – Chief Financial Officer	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A
Mary Louise E. Osborne Director	120 East Kensinger Drive Cranberry Twp., PA 16066	N/A
Tracy L. Smith Principal Officer – Vice President and Treasurer	200 Highland Corporate Dr. Cumberland, RI 02864	N/A
Robert M. Kessler Principal Officer – Vice President and Secretary	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A
Robert J. Parslow Principal Officer – Corporate Controller	151 Farmington Drive Hartford, CT 06156	N/A

[11] Please refer to **Appendix A** for a complete listing of office locations for CVS Health Corporation and Aetna Inc.

Name	Address[11]	Tax ID Number (entities)
Kevin J. Casey Principal Officer – Senior Investment Officer	151 Farmington Drive Hartford, CT 06156	N/A
Edward C. Lee Officer – Vice President and Assistant Secretary	151 Farmington Drive Hartford, CT 06156	N/A
Frank F. Chronister III Principal Officer – Assistant Controller	3721 TecPort Drive Harrisburg, PA 17111	N/A
Peter Keller Principal Officer – Assistant Controller	151 Farmington Drive Hartford, CT 06156	N/A
Bryan J. Lane Principal Officer – Assistant Controller	151 Farmington Drive Hartford, CT 06156	N/A
William S. Maynes Principal Officer – Assistant Controller	151 Farmington Drive Hartford, CT 06156	N/A
Robert T. O'Connor Officer – Vice President	11 Stanwix Street, Ste. 1400 Pittsburgh, PA 15237	N/A
Anne Kelly Berg Officer – Assistant Vice President	151 Farmington Ave. Hartford, CT 06156	N/A
Jennifer L. Pomponi Officer – Assistant Vice President	151 Farmington Ave. Hartford, CT 06156	N/A
Lindsay A. Chuey Officer – Assistant Treasurer	One CVS Drive Woonsocket, RI 02895	N/A
Robert S. Healy Officer – Assistant Treasurer	151 Farmington Ave. Hartford, CT 06156	N/A
Marc A. Parr Officer – Assistant Treasurer	151 Farmington Ave. Hartford, CT 06156	N/A
Diane E. Steponaitis Officer – Assistant Treasurer	151 Farmington Ave. Hartford, CT 06156	N/A
Sheelagh M. Beaulieu Officer – Assistant Secretary	One CVS Drive Woonsocket, RI 02895	N/A
Jeffrey E. Clark Officer – Assistant Secretary	One CVS Drive Woonsocket, RI 02895	N/A

Name	Address[11]	Tax ID Number (entities)
Deborah E. Finch Officer – Assistant Secretary	6720-B Rockledge Dr. Ste. 800 Bethesda, MD 20817	N/A
Caitlin M. Gould Officer – Assistant Secretary	151 Farmington Ave. Hartford, CT 06156	N/A
F. Ryan Keith Officer – Assistant Secretary	9900 Corporate Campus Drive Ste. 1000 Louisville, KY 40223	N/A
Cynthia A. Montano Officer – Assistant Secretary	151 Farmington Ave. Hartford, CT 06156	N/A
Thomas J. Rolwing Officer – Assistant Secretary	6720-B Rockledge Dr. Ste. 800 Bethesda, MD 20817	N/A
Melissa K. Ronski Officer – Assistant Secretary	151 Farmington Ave. Hartford, CT 06156	N/A
Timothy J. Roach Officer – Secretary	151 Farmington Ave. Hartford, CT 06156	N/A

- Tax identification number for a corporation with an ownership or control interest in the Vendor or in a subcontractor in which the Vendor has a five (5) percent or more interest.

Tax Identification Numbers

We have included the tax identification number for each corporation with an ownership or control interest in Aetna Better Health of West Virginia in **Table 3.1.1-2** in response to the question immediately preceding this one. Please note there are no subcontractors in which Aetna Better Health of West Virginia has a 5 percent or more ownership or control interest.

- Whether the person (individual or corporation) with ownership or control interest in the Vendor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

Related Parties with Ownership or Control Interest

In **Table 3.1.1-3**, we provide information regarding whether a person (individual or corporation) with ownership or control interest in Aetna Better Health of West Virginia and/or subcontractor is related to any other person with ownership or control interest.

Table 3.1.1-3: Relationships Between Individuals or Corporations with an Ownership or Control Interest

Name	Relationship to other Owners or others with Control Interest
CVS Health Corporation (Ultimate Owner)	CVS Health Corporation is the direct and ultimate owner of CVS Pharmacy, Inc., CVS Health Corporation is the indirect and ultimate owner of Aetna Inc., and Aetna Health Holdings, LLC.
CVS Pharmacy, Inc. (Indirect Owner)	CVS Pharmacy, Inc.'s direct and ultimate parent is CVS Health Corporation. CVS Pharmacy, Inc. is Aetna Inc.'s direct parent and an indirect parent of Aetna Health Holdings, LLC.
Aetna Inc. (Indirect Owner)	Aetna Inc.'s indirect and ultimate parent Is CVS Health Corporation, and its direct parent is CVS Pharmacy, Inc. Aetna Inc. is the direct parent of Aetna Health Holdings, LLC.
Aetna Health Holdings, LLC (Direct Owner)	Aetna Health Holdings, LLC's ultimate parent is CVS Health Corporation. CVS Pharmacy, Inc. is an indirect parent of Aetna Health Holdings, LLC. Aetna Health Holdings, LLC's direct parent is Aetna Inc.
David McNichols	None
David P. Delaney	None
Mary Louise E. Osborne	None
Tracy L. Smith	None
Robert M. Kessler	None
Kevin J. Casey	None
Robert J. Parslow	None
Edward C. Lee	None
Frank F. Chronister III	None
Peter Keller	None
Bryan J. Lane	None
William S. Maynes	None
Robert T. O'Connor	None
Anne Kelly Berg	None
Jennifer L. Pomponi	None
Lindsay A. Chuey	None
Robert S. Healy	None
Marc A. Parr	None

Name	Relationship to other Owners or others with Control Interest
Diane E. Steponaitis	None
Sheelagh M. Beaulieu	None
Jeffrey E. Clark	None
Deborah E. Finch	None
Caitlin M. Gould	None
F. Ryan Keith	None
Cynthia A. Montano	None
Thomas J. Rolwing	None
Melissa K. Ronski	None
Timothy J. Roach	None

- The name of any other organization in which a person with ownership or control interest in the Vendor also has an ownership or control interest.

Organizations in which a Person with Ownership or Control Interests in the Vendor also has an Ownership or Control Interest

Aetna Better Health of West Virginia provides the information below in accordance with 42 CFR §455.104(b)(3).[12]

Aetna Inc. and Aetna Health Holdings, LLC

- Aetna Better Health of North Carolina Inc.
- Aetna Better Health of California Inc.
- Aetna Better Health of Florida Inc.
- Aetna Better Health Inc., an Illinois Corporation dba Aetna Better Health of Illinois
- IlliniCare Health Plan, Inc.
- Aetna Better Health of Kansas Inc.
- Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky
- Aetna Better Health, Inc., a Louisiana Corporation dba Aetna Better Health of Louisiana
- Aetna Better Health of Michigan Inc.

[12] The first bullet point on page 59 of the RFP requests, "[t]he name of any other organization in which a person with ownership or control interest in the Vendor also has an ownership or control interest." The sentence immediately preceding the RFP questions requesting ownership and controlling interest information instructs Vendors to "provide the [requested] information in accordance with 42 CFR §455.104." See RFP page 58. As worded, the first bullet point on page 59 appears to be broader than what is requested by the corresponding CFR provision, which instead requires "the name of any other disclosing entity (or fiscal agency or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest." See 42 CFR §455.104(b)(3). Per the instruction on page 58, the information we provided in response to bullet point one on page 59 is in accordance with what is requested in 42 CFR §455.104(b)(3). If the Department seeks what appears to be the broader information requested in the first bullet point on page 59, we will provide additional information upon request.

- Aetna Better Health Inc., a New Jersey Corporation dba Aetna Better Health of New Jersey
- Aetna Better Health Inc., a New York Corporation dba Aetna Better Health of New York
- Aetna Better Health Inc., an Ohio Corporation dba Aetna Better Health of Ohio
- Aetna Better Health Inc., a Pennsylvania Corporation dba Aetna Better Health of Pennsylvania
- Aetna Health Inc., a Pennsylvania Corporation dba Aetna Better Health Kids
- Aetna Better Health of Texas Inc.
- Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia
- Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia
- Aetna Health of California Inc.
- Aetna Health Inc., a Georgia Corporation
- Coventry Health and Life Insurance Company
- Aetna Health of Iowa Inc. dba Coventry Health Care of Iowa, Inc.
- Coventry Health Care of Missouri, Inc. dba Care Management Resources (fictitious name: Coventry Health Care)
- Aetna Health Inc., a New Jersey Corporation
- Allina Health and Aetna Insurance Company
- Aetna Health Inc., a New York Corporation
- Aetna Health Inc., a Maine Corporation
- Aetna Health Inc., a Louisiana Corporation dba Coventry Health Care of Louisiana, Inc.
- Aetna Health Inc., a Pennsylvania Corporation
- Aetna Health Inc., a Pennsylvania Corporation dba HealthAmerica Pennsylvania
- Aetna Health Inc., a Texas Corporation
- Aetna Health Inc., a Georgia Corporation dba Coventry Health Care of Georgia, Inc.
- Coventry Health Care of Kansas, Inc.
- Aetna Life Insurance Company
- HealthAssurance Pennsylvania, Inc.
- Aetna Health Inc., a Connecticut Corporation
- Coventry Health Care of Nebraska, Inc. dba Aetna Health Better Health of Nebraska
- Coventry Health Care of Illinois, Inc.
- Aetna Health of Utah Inc. dba Altius Health Plans Inc.
- First Health Life & Health Insurance Company
- Innovation Health Insurance Company
- Innovation Health Plan, Inc.
- Aetna Dental Inc., a New Jersey Corporation
- Aetna Dental Inc., a Texas Corporation
- Aetna Dental of California Inc.
- Aetna Health and Life Insurance Company
- Aetna Health Inc., a Florida Corporation
- Aetna Health Inc., a Louisiana Corporation
- Aetna Health Inc., a Pennsylvania Corporation dba Aetna Better Health of Maryland
- Aetna Health Inc., a Michigan Corporation
- Aetna Health Insurance Company
- Aetna Health Insurance Company of New York
- Aetna Health of Iowa Inc.

- Aetna Health of Utah Inc.
- Aetna HealthAssurance Pennsylvania, Inc.
- American Continental Insurance Company
- Banner Health and Aetna Health Insurance Company
- Banner Health and Aetna Health Plan Inc.
- Continental Life Insurance Company of Brentwood, Tennessee
- Coventry Health Care of Florida, Inc.
- Coventry Health Care of Missouri, Inc.
- Coventry Health Care of Virginia, Inc.
- Coventry Health Care of West Virginia, Inc.
- Coventry Health Plan of Florida, Inc.
- Health and Human Resource Center, Inc.
- MHNet Life and Health Insurance Company
- Texas Health + Aetna Health Insurance Company
- Texas Health + Aetna Health Plan Inc

CVS Health Corporation

CVS Pharmacy, Inc.

CVS Pharmacy, Inc.[13]

- Alabama CVS Pharmacy, L.L.C.
- Alaska CVS Pharmacy, L.L.C.
- American Drug Stores Delaware, L.L.C.
- Arizona CVS Stores, L.L.C.
- Arkansas CVS Pharmacy, L.L.C.
- Busse CVS, L.L.C.
- CareCenter Pharmacy, L.L.C.
- Caremark Rx, L.L.C.
- Connecticut CVS Pharmacy, L.L.C.
- CVS 2948 Henderson, L.L.C.
- CVS 3268 Gilbert, L.L.C.
- CVS 3745 Peoria, L.L.C.
- CVS Albany, L.L.C.
- CVS Bellmore Avenue, L.L.C.
- CVS Gilbert 3272, L.L.C.
- CVS Manchester NH, L.L.C.
- CVS NV Holding Company, L.L.C.
- CVS PR Center, Inc
- CVS PR Holding Company, L.L.C.
- CVS RS Arizona, L.L.C.
- CVS Rx Services, Inc.

[13] These entities and their subsidiaries operate over 10,000 retail pharmacy, LTC pharmacy, mail service pharmacy, specialty pharmacy, prescription drug plan, infusion provider, and clinical provider locations. Detailed information is available upon request.

- CVS State Capital, L.L.C.
- D.A.W., L.L.C.
- Delaware CVS Pharmacy, L.L.C.
- District of Columbia CVS Pharmacy, L.L.C.
- Garfield Beach CVS, L.L.C.
- Georgia CVS Pharmacy, L.L.C.
- German Dobson CVS, L.L.C.
- Goodyear CVS, L.L.C.
- Grand St. Paul CVS, L.L.C.
- Highland Park CVS, L.L.C.
- Holiday CVS, L.L.C.
- Hook-SupeRX, L.L.C.
- Idaho CVS Pharmacy, L.L.C.
- Iowa CVS Pharmacy, L.L.C.
- Kansas CVS Pharmacy, L.L.C.
- Kentucky CVS Pharmacy, L.L.C.
- Longs Drug Stores California, L.L.C.
- Longs Drug Stores, L.L.C.
- Louisiana CVS Pharmacy, L.L.C.
- Maryland CVS Pharmacy, L.L.C.
- Melville Realty Company, Inc.
- MinuteClinic, L.L.C.
- Mississippi CVS Pharmacy, L.L.C.
- Missouri CVS Pharmacy, L.L.C.
- Montana CVS Pharmacy, L.L.C.
- Nebraska CVS Pharmacy, L.L.C.
- Nevada CVS Pharmacy, L.L.C.
- New Jersey CVS Pharmacy, L.L.C.
- North Carolina CVS Pharmacy, L.L.C.
- Ohio CVS Stores, L.L.C.
- Oklahoma CVS Pharmacy, L.L.C.
- Omnicare, Inc.
- Oregon CVS Pharmacy, L.L.C.
- Pennsylvania CVS Pharmacy, L.L.C.
- ProCare Pharmacy, L.L.C.
- Puerto Rico CVS Pharmacy, L.L.C.
- Rhode Island CVS Pharmacy, L.L.C.
- Sheffield Avenue CVS, L.L.C.
- South Carolina CVS Pharmacy, L.L.C.
- South Wabash CVS, L.L.C.
- Tennessee CVS Pharmacy, L.L.C.
- Thomas Phoenix CVS, L.L.C.
- Utah CVS Pharmacy, L.L.C.
- Vermont CVS Pharmacy, L.L.C.
- Virginia CVS Pharmacy, L.L.C.

- Warm Springs Road CVS, L.L.C.
- Washington CVS Pharmacy, L.L.C.
- Washington Lamb CVS, L.L.C.
- West Virginia CVS Pharmacy, L.L.C.
- Wisconsin CVS Pharmacy, L.L.C
- Woodward Detroit CVS, L.L.C.

- The Vendor should complete the Disclosure of Interested Parties to Contract Form, located at (http://www.state.wv.us/admin/purchase/VRC/Ethics_DisclosureInterestedParties_2018.pdf).

Disclosure of Interested Parties to Contract

Aetna Better Health of West Virginia has included the completed Disclosure of Interested Parties to Contract Form under the **Signed Forms** tab.

Please describe if the Vendor has ever sought, or is currently seeking, NCQA accreditation status, and indicate: if NCQA-accredited, its current NCQA accreditation status and its accreditation term effective dates; and if not accredited, a statement describing whether and when NCQA accreditation status was ever denied. NCQA accreditation is required within nine (9) months of the contract effective date.

National Committee for Quality Assurance

Aetna Better Health of West Virginia's NCQA accreditation status is 'Commendable' for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.



Aetna Better Health of West Virginia was the first Medicaid managed care organization with Commendable status in West Virginia and the only plan to maintain Commendable status without interruption since 2016. Our accreditation term effective dates are September 20, 2019 through September 20, 2022. A copy of our certificate is included in **Appendix B.** In addition to our successful NCQA outcomes, ABHWV has achieved a 100 percent final EQRO audit score in three of the last four years, with a 99 percent final score in calendar year 2017. Aetna Better Health of West Virginia's NCQA and EQRO results are evidence of our focus on quality outcomes to support our mission to improve every life we serve.

1.2 Subcontractor Overview

If the proposal includes the use of subcontractor(s), excluding direct-care providers, provide all relevant information regarding the profile of each subcontractor. The Vendor should provide their response as part of their bid in accordance with the template below. This section may be duplicated in its entirety, and a page created per subcontractor included.

In **Table 6: Subcontractor Overview** below, we provide the requested information for each of the following subcontractors[1] that Aetna Better Health of West Virginia will utilize to support the Medicaid and WVCHIP programs, if awarded:

- Active Health Management, Inc.
- Aetna Health Management, LLC
- Aetna Medicaid Administrators LLC
- Center for the Study of Services
- Change Healthcare Solutions, LLC
- Cotiviti, Inc.
- CQ Fluency
- Equian, LLC
- eviCore healthcare MSI, LLC d/b/a eviCore healthcare (f/k/a MedSolutions, Inc.)
- First Choice Services, Inc.
- Health Management Systems, Inc.
- Inovalon, Inc.
- MCMC, LLC
- NantHealth, Inc.
- Prest & Associates, LLC
- SKYGEN USA, LLC
- Symphony Performance Health, Inc. d/b/a SPH Analytics
- Vision Service Plan Insurance Company
- Welltok, Inc.

[1] Aetna Better Health of West Virginia delegates credentialing to certain providers in its provider network. We do not understand the definition of "Subcontractor" to include providers performing credentialing functions for themselves. Accordingly, we have not listed them as Subcontractors or provided for them the information and disclosures required of Subcontractors throughout the RFP. If our understanding is incorrect, we will provide any additional information the Department seeks regarding these providers upon request.

The Vendor is NOT to change any of the pre-filled cells in the following tables.

Active Health Management, Inc.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Active Health Management, Inc. (ActiveHealth)
Name of Parent Company (If Applicable)	ActiveHealth's direct parent is Aetna Inc. CVS Pharmacy, Inc. is an indirect parent of ActiveHealth. CVS Health Corporation is ActiveHealth's ultimate parent.
Tax Identification Number	52-2182411
Industry (NAICS)	N/A
Type of Legal Entity	For-profit corporation
Company Ownership (e.g., Private/Public, Joint Venture)	ActiveHealth's direct parent is Aetna Inc. CVS Pharmacy, Inc. is an indirect parent of Active Health Management, Inc. Active Health's ultimate parent is CVS Health Corporation.
Number of Full-Time Employees	ActiveHealth has approximately 820 staff members, which are employed by Aetna Resources LLC (Aetna Resources), an Employee Management Company and Aetna affiliate that provides labor services.
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	CONFIDENTIAL: $51.0M
Last Fiscal Year Company Net Income	ActiveHealth is not a separately reported segment, so Net Income information at that level of detail is unavailable. ActiveHealth's financial information is part of CVS Health Corporation's financials. CVS Health Corporations Q3 10-K report is provided in **Appendix D.**
% of Revenue From State Government Clients in the United States	CONFIDENTIAL: 53 percent
Number of Years in Business	22 years. ActiveHealth was incorporated and began operations in 1998.
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	ActiveHealth has been providing services to Aetna Medicaid health plans for 11 years.
Number of Employees Providing the Type of Services Specified in the RFP	ActiveHealth has approximately 820 staff members, which are employed by Aetna Resources LLC (Aetna Resources), an Employee Management Company and Aetna affiliate that provides labor services.
Headquarters in the United States	Yes

Subcontractor Overview	
Headquarters Mailing Address	233 Spring Street 13th Floor, New York, NY 10013
Street Address	233 Spring Street 13th Floor, New York, NY 10013
Telephone Number	212-651-8200
Fax Number	N/A
Locations in the United States	ActiveHealth's corporate office is located in New York with operational sites in Arizona, Colorado, Georgia, Illinois, North Carolina, and Virginia.
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** same as above **Mailing Address:** same as above **Street Address:** same as above **Telephone Number:** same as above **Fax Number:** same as above
Name of Contact Person for Bid	Mohamed Diab, CEO

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

We have included the requested information in **Table 3.1.2-1** for any person (individual or corporation) with an ownership or control interest in ActiveHealth, other than institutional investors with a beneficial ownership of 5 percent or more of CVS Health Corporation's common stock.

Please note that ActiveHealth ultimate parent, CVS Health Corporation, is a publicly traded company, listed on the New York Stock Exchange and registered with the Securities Exchange Commission ("SEC"). As a publicly traded company, CVS Health Corporation does not track the identity of individual shareholders but relies on disclosures of beneficial ownership of CVS

Health Corporation stock, which the SEC requires investors to file on Schedules 13D and 13G and related amendments.

From time to time, certain institutional investors have filed Schedules 13D and 13G with the SEC, indicating beneficial ownership of 5 percent or more of CVS Health Corporation's common stock. In such filings, the beneficial owner certifies that their shares were acquired in the ordinary course of business and were not acquired for the purpose of changing or influencing the control of CVS Health Corporation.

Table 3.1.2-1: Name, Address and Tax ID Number of Any Person (Individual or Corporation) with an Ownership or Control Interest in ActiveHealth

Name	Address[2]	Tax ID Number (entities)
CVS Health Corporation (Ultimate Owner)	One CVS Drive Woonsocket, RI 02895	05-0494040
CVS Pharmacy, Inc. (Indirect Owner)	One CVS Drive Woonsocket, RI 02895	05-0340626
Aetna Inc. (Direct Owner)	151 Farmington Drive Hartford, CT 06156	23-2229863
Mohamed Diab Sole Director – Principal Officer, Chief Executive Officer & President	1333 Broadway New York, NY 10018	N/A
Matthew J. Asmus Principal Officer -- Executive Vice President & Chief Financial Officer	1333 Broadway New York, NY 10018	N/A
Tracy L. Smith Principal Officer – Vice President & Treasurer	200 Highland Corporate Dr. Cumberland, RI 02864	N/A
Edward Chung-I Lee Principal Officer – Vice President & Secretary	151 Farmington Drive Hartford, CT 06156	N/A

[2] Please refer to **Appendix A** for a complete listing of office locations for CVS Health Corporation and Aetna Inc.

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

We have included the Tax Identification Number for each corporation with an ownership or control interest in ActiveHealth in **Table 3.1.2-1** in response to the question immediately preceding this one. Please note there are no subcontractors in which ActiveHealth has a five (5) percent or more ownership or control interest.

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

In **Table 3.1.2-2**, we indicate whether a person (individual or corporation) with ownership or control interest in the Subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

Table 3.1.2-2: Relationships Among Persons with Ownership or Control Interest in ActiveHealth

Name	Relationship to other Owners or others with Control Interest
CVS Health Corporation (Ultimate Owner)	CVS Health Corporation is the direct owner of CVS Pharmacy, Inc. CVS Health Corporation is the indirect and ultimate parent of Aetna Inc. and ActiveHealth.
CVS Pharmacy, Inc. (Indirect Owner)	CVS Pharmacy, Inc.'s direct and ultimate owner is CVS Health Corporation. CVS Pharmacy, Inc. is the direct owner of Aetna Inc. and an indirect parent of ActiveHealth.
Aetna Inc. (Direct Owner)	Aetna Inc.'s ultimate owner is CVS Health Corporation, and its direct owner is CVS Pharmacy, Inc. Aetna Inc. is ActiveHealth's direct parent.
Mohamed Diab	None
Matthew J. Asmus	None
Tracy L. Smith	None
Edward Chung-I Lee	None

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

ActiveHealth provides the following information in accordance with 42 CFR 455.104(b)(3), as applied to Subcontractors.[3]

Aetna Inc.

- Aetna Better Health of North Carolina Inc.
- Aetna Better Health of California Inc.
- Aetna Better Health of Florida Inc.
- Aetna Better Health Inc., an Illinois Corporation dba Aetna Better Health of Illinois
- IlliniCare Health Plan, Inc.
- Aetna Better Health of Kansas Inc.
- Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky
- Aetna Better Health, Inc., a Louisiana Corporation dba Aetna Better Health of Louisiana
- Aetna Better Health of Michigan Inc.
- Aetna Better Health Inc., a New Jersey Corporation dba Aetna Better Health of New Jersey
- Aetna Better Health Inc., a New York Corporation dba Aetna Better Health of New York
- Aetna Better Health Inc., an Ohio Corporation dba Aetna Better Health of Ohio
- Aetna Better Health Inc., a Pennsylvania Corporation dba Aetna Better Health of Pennsylvania
- Aetna Health Inc., a Pennsylvania Corporation dba Aetna Better Health Kids
- Aetna Better Health of Texas Inc.
- Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia
- Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia
- Aetna Health of California Inc.
- Aetna Health Inc., a Georgia Corporation
- Coventry Health and Life Insurance Company
- Aetna Health of Iowa Inc. d/b/a Coventry Health Care of Iowa, Inc.
- Coventry Health Care of Missouri, Inc. dba Care Management Resources (fictitious name: Coventry Health Care)
- Aetna Health Inc., a New Jersey Corporation
- Allina Health and Aetna Insurance Company
- Aetna Health Inc., a New York Corporation
- Aetna Health Inc., a Maine Corporation

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[3] The sentence immediately preceding the RFP questions requesting ownership and controlling interest information instructs Subcontractors to "provide the [requested] information in accordance with 42 CFR §455.104." Please refer to RFP page 60. The requirement in 42 CFR 455.104(b)(3) appears to most closely mirror what is requested here. As worded, however, this RFP request is broader than what is required by 42 CFR 455 104(b)(3), which if re-worded to apply to Subcontractors would require disclosure of "the name of any other disclosing entity (or fiscal agency or managed care entity) in which an owner of the [Subcontractor] (or fiscal agent or managed care entity) has an ownership interest." Applying the instruction on page 60, the information we provided in response to this request is in accordance with what is requested in 42 CFR §455.104(b)(3), as reworded to apply to Subcontractors. If the Department disagrees with our approach or seeks what appears to be the broader information requested here, we will provide additional information upon request.

- Aetna Health Inc., a Louisiana Corporation d/b/a Coventry Health Care of Louisiana, Inc.
- Aetna Health Inc., a Pennsylvania Corporation
- Aetna Health Inc., a Pennsylvania Corporation d/b/a HealthAmerica Pennsylvania
- Aetna Health Inc., a Texas Corporation
- Aetna Health Inc., a Georgia Corporation d/b/a Coventry Health Care of Georgia, Inc.
- Coventry Health Care of Kansas, Inc.
- Aetna Life Insurance Company
- HealthAssurance Pennsylvania, Inc.
- Aetna Health Inc., a Connecticut Corporation
- Coventry Health Care of Nebraska, Inc. d/b/a Aetna Health Better Health of Nebraska
- Coventry Health Care of Illinois, Inc.
- Aetna Health of Utah Inc. d/b/a Altius Health Plans Inc.
- First Health Life & Health Insurance Company
- Innovation Health Insurance Company
- Innovation Health Plan, Inc.
- Aetna Dental Inc., a New Jersey Corporation
- Aetna Dental Inc., a Texas Corporation
- Aetna Dental of California Inc.
- Aetna Health and Life Insurance Company
- Aetna Health Inc., a Florida Corporation
- Aetna Health Inc., a Louisiana Corporation
- Aetna Health Inc., a Pennsylvania Corporation d/b/a Aetna Better Health of Maryland
- Aetna Health Inc., a Michigan Corporation
- Aetna Health Insurance Company
- Aetna Health Insurance Company of New York
- Aetna Health of Iowa Inc.
- Aetna Health of Utah Inc.
- Aetna HealthAssurance Pennsylvania, Inc.
- American Continental Insurance Company
- Banner Health and Aetna Health Insurance Company
- Banner Health and Aetna Health Plan Inc.
- Continental Life Insurance Company of Brentwood, Tennessee
- Coventry Health Care of Florida, Inc.
- Coventry Health Care of Missouri, Inc.
- Coventry Health Care of Virginia, Inc.
- Coventry Health Care of West Virginia, Inc.
- Coventry Health Plan of Florida, Inc.
- Health and Human Resource Center, Inc.
- MHNet Life and Health Insurance Company
- Texas Health + Aetna Health Insurance Company
- Texas Health + Aetna Health Plan Inc.

CVS Health Corporation

- CVS Pharmacy, Inc.

CVS Pharmacy, Inc.[4]

- Alabama CVS Pharmacy, L.L.C.
- Alaska CVS Pharmacy, L.L.C.
- American Drug Stores Delaware, L.L.C.
- Arizona CVS Stores, L.L.C.
- Arkansas CVS Pharmacy, L.L.C.
- Busse CVS, L.L.C.
- CareCenter Pharmacy, L.L.C.
- Caremark Rx, L.L.C.
- Connecticut CVS Pharmacy, L.L.C.
- CVS 2948 Henderson, L.L.C.
- CVS 3268 Gilbert, L.L.C.
- CVS 3745 Peoria, L.L.C.
- CVS Albany, L.L.C.
- CVS Bellmore Avenue, L.L.C.
- CVS Gilbert 3272, L.L.C.
- CVS Manchester NH, L.L.C.
- CVS NV Holding Company, L.L.C.
- CVS PR Center, Inc
- CVS PR Holding Company, L.L.C.
- CVS RS Arizona, L.L.C.
- CVS Rx Services, Inc.
- CVS State Capital, L.L.C.
- D.A.W., L.L.C.
- Delaware CVS Pharmacy, L.L.C.
- District of Columbia CVS Pharmacy, L.L.C.
- Garfield Beach CVS, L.L.C.
- Georgia CVS Pharmacy, L.L.C.
- German Dobson CVS, L.L.C.
- Goodyear CVS, L.L.C.
- Grand St. Paul CVS, L.L.C.
- Highland Park CVS, L.L.C.
- Holiday CVS, L.L.C.
- Hook-SupeRX, L.L.C.
- Idaho CVS Pharmacy, L.L.C.
- Iowa CVS Pharmacy, L.L.C.
- Kansas CVS Pharmacy, L.L.C.
- Kentucky CVS Pharmacy, L.L.C.
- Longs Drug Stores California, L.L.C.
- Longs Drug Stores, L.L.C.
- Louisiana CVS Pharmacy, L.L.C.

[4] These entities and their subsidiaries operate over 10,000 retail pharmacy, LTC pharmacy, mail service pharmacy, specialty pharmacy, PDP, infusion provider and clinical provider locations. Detailed information is available upon request.

- Maryland CVS Pharmacy, L.L.C.
- Melville Realty Company, Inc.
- MinuteClinic, L.L.C.
- Mississippi CVS Pharmacy, L.L.C.
- Missouri CVS Pharmacy, L.L.C.
- Montana CVS Pharmacy, L.L.C.
- Nebraska CVS Pharmacy, L.L.C.
- Nevada CVS Pharmacy, L.L.C.
- New Jersey CVS Pharmacy, L.L.C.
- North Carolina CVS Pharmacy, L.L.C.
- Ohio CVS Stores, L.L.C.
- Oklahoma CVS Pharmacy, L.L.C.
- Omnicare, Inc.
- Oregon CVS Pharmacy, L.L.C.
- Pennsylvania CVS Pharmacy, L.L.C.
- ProCare Pharmacy, L.L.C.
- Puerto Rico CVS Pharmacy, L.L.C.
- Rhode Island CVS Pharmacy, L.L.C.
- Sheffield Avenue CVS, L.L.C.
- South Carolina CVS Pharmacy, L.L.C.
- South Wabash CVS, L.L.C.
- Tennessee CVS Pharmacy, L.L.C.
- Thomas Phoenix CVS, L.L.C.
- Utah CVS Pharmacy, L.L.C.
- Vermont CVS Pharmacy, L.L.C.
- Virginia CVS Pharmacy, L.L.C.
- Warm Springs Road CVS, L.L.C.
- Washington CVS Pharmacy, L.L.C.
- Washington Lamb CVS, L.L.C.
- West Virginia CVS Pharmacy, L.L.C.
- Wisconsin CVS Pharmacy, L.L.C.
- Woodward Detroit CVS, L.L.C

Aetna Health Management, LLC

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Aetna Health Management, LLC (Aetna Health Management)
Name of Parent Company (If Applicable)	Aetna Health Management's direct parent is Aetna Health Holdings, LLC. Aetna Inc. and CVS Pharmacy, Inc. are indirect parents of Aetna Health Management. CVS Health Corporation is Aetna Health Management's ultimate parent.
Tax Identification Number	13-3670795
Industry (NAICS)	N/A
Type of Legal Entity	For-profit limited liability company
Company Ownership (e.g., Private/Public, Joint Venture)	Aetna Health Management's direct parent, Aetna Health Holdings, LLC, is a private company. Aetna Inc. and CVS Pharmacy, Inc., two of Aetna Health Management's indirect parents, are also private companies. CVS Health Corporation, Aetna Health Management's ultimate parent, is a publicly traded company.
Number of Full-Time Employees	Aetna Health Management has no employees. All staff of Aetna Health Management are employed by Aetna Resources LLC, an Employee Management Company and Aetna affiliate that provides labor services. Aetna Resources LLC has over 40,000 employees. Staffing assignments are based on staffing needs necessary to meet contract requirements. The number of Aetna Health Management staff that will support any contract awarded as a result of this RFP will be based on the number of staff needed to fulfill our contractual obligations and will be sufficient to meet those obligations.
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$6.6 million
Last Fiscal Year Company Net Income	$292.6 million
% of Revenue From State Government Clients in the United States	0%
Number of Years in Business	Approximately 27. Aetna Health Management was established in June 1992 and began operations in May 1993.
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	Aetna Health Management has been providing services to Aetna's Medicaid health plans nationally for 15 years.
Number of Employees Providing the Type of Services Specified in the RFP	Aetna Health Management has no employees. All staff of Aetna Health Management are employed by Aetna Resources LLC, an

Subcontractor Overview	
	Employee Management Company and Aetna affiliate that provides labor services. Aetna Resources LLC has over 40,000 employees. Staffing assignments are based on staffing needs necessary to meet contract requirements. The number of Aetna Health Management staff that will support any contract awarded as a result of this RFP will be based on the number of staff needed to fulfill our contractual obligations and will be sufficient to meet those obligations.
Headquarters in the United States	Yes
Headquarters Mailing Address	151 Farmington Avenue, Hartford, Connecticut 06156
Street Address	151 Farmington Avenue, Hartford, Connecticut 06156
Telephone Number	860-273-0123
Fax Number	N/A
Locations in the United States	Connecticut
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** same as above **Mailing Address:** same as above **Street Address:** same as above **Telephone Number:** same as above **Fax Number:** same as above
Name of Contact Person for Bid	Sheryl Burke Adkins, President

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

We have included the requested information in **Table 3.1.2-3** for any person (individual or corporation) with an ownership or control interest in Aetna Health Management, other than institutional investors with a beneficial ownership of 5 percent or more of CVS Health Corporation's common stock.

Please note that Aetna Health Management ultimate parent, CVS Health Corporation, is a publicly traded company, listed on the New York Stock Exchange and registered with the

Securities Exchange Commission (SEC). As a publicly traded company, CVS Health Corporation does not track the identity of individual shareholders but relies on disclosures of beneficial ownership of CVS Health Corporation stock, which the SEC requires investors to file on Schedules 13D and 13G and related amendments.

From time to time, certain institutional investors have filed Schedules 13D and 13G with the SEC, indicating beneficial ownership of 5 percent or more of CVS Health Corporation's common stock. In such filings, the beneficial owner certifies that their shares were acquired in the ordinary course of business and were not acquired for the purpose of changing or influencing the control of CVS Health Corporation.

Table 3.1.2-3: Name, Address, and Tax ID Number of Any Person (Individual or Corporation) with an Ownership or Control Interest in Aetna Health Management

Name	Address[5]	Tax ID Number (Entities)
CVS Health Corporation (Ultimate Owner)	One CVS Drive Woonsocket, RI 02895	05-0494040
CVS Pharmacy, Inc. (Indirect Owner)	One CVS Drive Woonsocket, RI 02895	05-0340626
Aetna Inc. (Indirect Owner)	151 Farmington Drive Hartford, CT 06156	23-2229863
Aetna Health Holdings, LLC (Direct Owner)	151 Farmington Drive Hartford, CT 06156	30-0123754
Sheryl Burke Adkins Principal Officer – President	151 Farmington Drive Hartford, CT 06156	N/A
Lisa Perdikakis Principal Officer – Vice President & Controller	151 Farmington Drive Hartford, CT 06156	N/A
Tracy L. Smith Principal Officer – Vice President & Treasurer	200 Highland Corporate Dr. Cumberland, RI 02864	N/A

[5] Please refer to **Appendix A** for a complete listing of office locations for CVS Health Corporation and Aetna Inc.

Name	Address[5]	Tax ID Number (Entities)
Edward C. Lee Principal Officer – Vice President & Secretary	151 Farmington Drive Hartford, CT 06156	N/A

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

We have included the Tax Identification Number for each corporation with an ownership or control interest in Aetna Health Management in **Table 3.1.2-3** in response to the question immediately preceding this one. Please note there are no subcontractors in which Aetna Health Management has a five percent or more ownership or control interest.

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

In **Table 3.1.2-4,** we indicate whether a person (individual or corporation) with ownership or control interest in the Subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

Table 3.1.2-4: Relationships Among Persons with Ownership or Control Interest in Aetna Health Management

Name	Relationship to other Owners or others with Control Interest
CVS Health Corporation (Ultimate Owner)	CVS Health Corporation is the direct owner of CVS Pharmacy, Inc. CVS Health Corporation is the indirect and ultimate owner of Aetna Inc., Aetna Health Holdings, LLC, CVS Pharmacy, Inc., and Aetna Health Management.
CVS Pharmacy, Inc. (Indirect Owner)	CVS Pharmacy, Inc.'s direct and ultimate parent is CVS Health Corporation. CVS Pharmacy, Inc. is Aetna Inc.'s direct parent and an indirect parent of Aetna Health Holdings, LLC and Aetna Health Management.
Aetna Inc. (Indirect Owner)	Aetna Inc.'s ultimate parent Is CVS Health Corporation, and its direct parent is CVS Pharmacy, Inc. Aetna Inc. is the direct parent of Aetna Health Holdings, LLC. and an indirect parent of Aetna Health Management.

Name	Relationship to other Owners or others with Control Interest
Aetna Health Holdings, LLC (Direct Owner)	Aetna Health Holdings, LLC's ultimate parent is CVS Health Corporation. CVS Pharmacy, Inc. is an indirect parent of Aetna Health Holdings, LLC. Aetna Health Holdings, LLC's direct parent is Aetna Inc. Aetna Health Holdings, LLC is the direct parent of Aetna Health Management.
Sheryl Burke Adkins	None
Lisa Perdikakis	None
Tracy L. Smith	None
Edward Chung-I Lee	None

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

Aetna Health Management provides the following information in accordance with 42 CFR

455.104(b)(3), as applied to Subcontractors[6].

Aetna Inc. and Aetna Health Holdings, LLC

- Aetna Better Health of North Carolina Inc.
- Aetna Better Health of California Inc.
- Aetna Better Health of Florida Inc.
- Aetna Better Health Inc., an Illinois Corporation dba Aetna Better Health of Illinois
- IlliniCare Health Plan, Inc.
- Aetna Better Health of Kansas Inc.
- Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky
- Aetna Better Health, Inc., a Louisiana Corporation dba Aetna Better Health of Louisiana
- Aetna Better Health of Michigan Inc.
- Aetna Better Health Inc., a New Jersey Corporation dba Aetna Better Health of New Jersey
- Aetna Better Health Inc., a New York Corporation dba Aetna Better Health of New York
- Aetna Better Health Inc., an Ohio Corporation dba Aetna Better Health of Ohio
- Aetna Better Health Inc., a Pennsylvania Corporation dba Aetna Better Health of Pennsylvania

[6] The sentence immediately preceding the RFP questions requesting ownership and controlling interest information instructs Subcontractors to "provide the [requested] information in accordance with 42 CFR §455.104." Please refer to RFP page 60. The requirement in 42 CFR 455.104(b)(3) appears to most closely mirror what is requested here. As worded, however, this RFP request is broader than what is required by 42 CFR 455 104(b)(3), which if re-worded to apply to Subcontractors would require disclosure of "the name of any other disclosing entity (or fiscal agency or managed care entity) in which an owner of the [Subcontractor] (or fiscal agent or managed care entity) has an ownership interest." Applying the instruction on page 60, the information we provided in response to this request is in accordance with what is requested in 42 CFR §455.104(b)(3), as reworded to apply to Subcontractors. If the Department disagrees with our approach or seeks what appears to be the broader information requested here, we will provide additional information upon request.

- Aetna Health Inc., a Pennsylvania Corporation dba Aetna Better Health Kids
- Aetna Better Health of Texas Inc.
- Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia
- Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia
- Aetna Health of California Inc.
- Aetna Health Inc., a Georgia Corporation
- Coventry Health and Life Insurance Company
- Aetna Health of Iowa Inc. d/b/a Coventry Health Care of Iowa, Inc.
- Coventry Health Care of Missouri, Inc. dba Care Management Resources (fictitious name: Coventry Health Care)
- Aetna Health Inc., a New Jersey Corporation
- Allina Health and Aetna Insurance Company
- Aetna Health Inc., a New York Corporation
- Aetna Health Inc., a Maine Corporation
- Aetna Health Inc., a Louisiana Corporation d/b/a Coventry Health Care of Louisiana, Inc.
- Aetna Health Inc., a Pennsylvania Corporation
- Aetna Health Inc., a Pennsylvania Corporation d/b/a HealthAmerica Pennsylvania
- Aetna Health Inc., a Texas Corporation
- Aetna Health Inc., a Georgia Corporation d/b/a Coventry Health Care of Georgia, Inc.
- Coventry Health Care of Kansas, Inc.
- Aetna Life Insurance Company
- HealthAssurance Pennsylvania, Inc.
- Aetna Health Inc., a Connecticut Corporation
- Coventry Health Care of Nebraska, Inc. d/b/a Aetna Health Better Health of Nebraska
- Coventry Health Care of Illinois, Inc.
- Aetna Health of Utah Inc. d/b/a Altius Health Plans Inc.
- First Health Life & Health Insurance Company
- Innovation Health Insurance Company
- Innovation Health Plan, Inc.
- Aetna Dental Inc., a New Jersey Corporation
- Aetna Dental Inc., a Texas Corporation
- Aetna Dental of California Inc.
- Aetna Health and Life Insurance Company
- Aetna Health Inc., a Florida Corporation
- Aetna Health Inc., a Louisiana Corporation
- Aetna Health Inc., a Pennsylvania Corporation d/b/a Aetna Better Health of Maryland
- Aetna Health Inc., a Michigan Corporation
- Aetna Health Insurance Company
- Aetna Health Insurance Company of New York
- Aetna Health of Iowa Inc.
- Aetna Health of Utah Inc.
- Aetna HealthAssurance Pennsylvania, Inc.
- American Continental Insurance Company
- Banner Health and Aetna Health Insurance Company
- Banner Health and Aetna Health Plan Inc.

- Continental Life Insurance Company of Brentwood, Tennessee
- Coventry Health Care of Florida, Inc.
- Coventry Health Care of Missouri, Inc.
- Coventry Health Care of Virginia, Inc.
- Coventry Health Care of West Virginia, Inc.
- Coventry Health Plan of Florida, Inc.
- Health and Human Resource Center, Inc.
- MHNet Life and Health Insurance Company
- Texas Health + Aetna Health Insurance Company
- Texas Health + Aetna Health Plan Inc.

CVS Health Corporation

- CVS Pharmacy, Inc.

CVS Pharmacy, Inc.[7]

- Alabama CVS Pharmacy, L.L.C.
- Alaska CVS Pharmacy, L.L.C.
- American Drug Stores Delaware, L.L.C.
- Arizona CVS Stores, L.L.C.
- Arkansas CVS Pharmacy, L.L.C.
- Busse CVS, L.L.C.
- CareCenter Pharmacy, L.L.C.
- Caremark Rx, L.L.C.
- Connecticut CVS Pharmacy, L.L.C.
- CVS 2948 Henderson, L.L.C.
- CVS 3268 Gilbert, L.L.C.
- CVS 3745 Peoria, L.L.C.
- CVS Albany, L.L.C.
- CVS Bellmore Avenue, L.L.C.
- CVS Gilbert 3272, L.L.C.
- CVS Manchester NH, L.L.C.
- CVS NV Holding Company, L.L.C.
- CVS PR Center, Inc
- CVS PR Holding Company, L.L.C.
- CVS RS Arizona, L.L.C.
- CVS Rx Services, Inc.
- CVS State Capital, L.L.C.
- D.A.W., L.L.C.
- Delaware CVS Pharmacy, L.L.C.
- District of Columbia CVS Pharmacy, L.L.C.
- Garfield Beach CVS, L.L.C.
- Georgia CVS Pharmacy, L.L.C.

[7] These entities and their subsidiaries operate over 10,000 retail pharmacy, LTC pharmacy, mail service pharmacy, specialty pharmacy, PDP, infusion provider and clinical provider locations. Detailed information is available upon request.

- German Dobson CVS, L.L.C.
- Goodyear CVS, L.L.C.
- Grand St. Paul CVS, L.L.C.
- Highland Park CVS, L.L.C.
- Holiday CVS, L.L.C.
- Hook-SupeRX, L.L.C.
- Idaho CVS Pharmacy, L.L.C.
- Iowa CVS Pharmacy, L.L.C.
- Kansas CVS Pharmacy, L.L.C.
- Kentucky CVS Pharmacy, L.L.C.
- Longs Drug Stores California, L.L.C.
- Longs Drug Stores, L.L.C.
- Louisiana CVS Pharmacy, L.L.C.
- Maryland CVS Pharmacy, L.L.C.
- Melville Realty Company, Inc.
- MinuteClinic, L.L.C.
- Mississippi CVS Pharmacy, L.L.C.
- Missouri CVS Pharmacy, L.L.C.
- Montana CVS Pharmacy, L.L.C.
- Nebraska CVS Pharmacy, L.L.C.
- Nevada CVS Pharmacy, L.L.C.
- New Jersey CVS Pharmacy, L.L.C.
- North Carolina CVS Pharmacy, L.L.C.
- Ohio CVS Stores, L.L.C.
- Oklahoma CVS Pharmacy, L.L.C.
- Omnicare, Inc.
- Oregon CVS Pharmacy, L.L.C.
- Pennsylvania CVS Pharmacy, L.L.C.
- ProCare Pharmacy, L.L.C.
- Puerto Rico CVS Pharmacy, L.L.C.
- Rhode Island CVS Pharmacy, L.L.C.
- Sheffield Avenue CVS, L.L.C.
- South Carolina CVS Pharmacy, L.L.C.
- South Wabash CVS, L.L.C.
- Tennessee CVS Pharmacy, L.L.C.
- Thomas Phoenix CVS, L.L.C.
- Utah CVS Pharmacy, L.L.C.
- Vermont CVS Pharmacy, L.L.C.
- Virginia CVS Pharmacy, L.L.C.
- Warm Springs Road CVS, L.L.C.
- Washington CVS Pharmacy, L.L.C.
- Washington Lamb CVS, L.L.C.
- West Virginia CVS Pharmacy, L.L.C.
- Wisconsin CVS Pharmacy, L.L.C.
- Woodward Detroit CVS, L.L.C

Aetna Medicaid Administrators LLC

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Aetna Medicaid Administrators LLC (Aetna Medicaid Administrators)
Name of Parent Company (If Applicable)	Aetna Medicaid Administrators' direct parent is Aetna Health Holdings, LLC. Aetna Inc. and CVS Pharmacy, Inc. are indirect parents of Aetna Medicaid Administrators. CVS Health Corporation is Aetna Medicaid Administrators ultimate parent.
Tax Identification Number	86-0842559
Industry (NAICS)	NAIC# 95408
Type of Legal Entity	For-profit limited liability company
Company Ownership (e.g., Private/Public, Joint Venture)	Aetna Medicaid Administrators' direct parent is Aetna Health Holdings, LLC, a private company. Two of its indirect parents, Aetna Inc. and CVS Pharmacy, Inc., are also private companies. Aetna Medicaid Administrators' ultimate parent, CVS Health Corporation, is a publicly traded company.
Number of Full-Time Employees	Over 5,000
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$341.7 million (2018 Fiscal Year)
Last Fiscal Year Company Net Income	$58.1 million (2018 Fiscal Year)
% of Revenue From State Government Clients in the United States	0%
Number of Years in Business	Approximately 23 years. Aetna Medicaid Administrators LLC was incorporated on November 15, 1996 as Schaller Anderson of Arizona, L.L.C. Through a series of name changes, Schaller Anderson of Arizona, L.L.C. became what is currently known as Aetna Medicaid Administrators LLC.
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	23 years
Number of Employees Providing the Type of Services Specified in the RFP	Over 5,000
Headquarters in the United States	Yes
Headquarters Mailing Address	4500 E. Cotton Center Boulevard, Bldg. 1, Suite 200 Phoenix, AZ 85040

Subcontractor Overview	
Street Address	4500 E. Cotton Center Boulevard, Bldg. 1, Suite 200 Phoenix, AZ 85040
Telephone Number	602-659-1100
Fax Number	N/A
Locations in the United States	Arizona
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** same as above **Mailing Address:** same as above **Street Address:** same as above **Telephone Number:** same as above **Fax Number:** same as above
Name of Contact Person for Bid	David McNichols

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

We have included the requested information **Table 3.1.2-5** for any person (individual or corporation) with an ownership or control interest in Aetna Medicaid Administrators, other than institutional investors with a beneficial ownership of 5 percent or more of CVS Health Corporation's common stock.

Please note that Aetna Medicaid Administrators' ultimate parent, CVS Health Corporation, is a publicly traded company, listed on the New York Stock Exchange and registered with the Securities Exchange Commission (SEC). As a publicly traded company, CVS Health Corporation does not track the identity of individual shareholders but relies on disclosures of beneficial ownership of CVS Health Corporation stock, which the SEC requires investors to file on Schedules 13D and 13G and related amendments.

From time to time, certain institutional investors have filed Schedules 13D and 13G with the SEC, indicating beneficial ownership of 5 percent or more of CVS Health Corporation's common stock. In such filings, the beneficial owner certifies that their shares were acquired in the ordinary course of business and were not acquired for the purpose of changing or influencing the control of CVS Health Corporation.

Table 3.1.2-5: Name, Address and Tax ID Number of Any Person (Individual or Corporation) with an Ownership or Control Interest in Aetna Medicaid Administrators

Name	Address[8]	Tax ID Number (entities)
CVS Health Corporation (Ultimate Owner)	One CVS Drive Woonsocket, RI 02895	05-0494040
CVS Pharmacy, Inc. (Indirect Owner)	One CVS Drive Woonsocket, RI 02895	05-0340626
Aetna Inc. (Indirect Owner)	151 Farmington Drive Hartford, CT 06156	23-2229863
Aetna Health Holdings, LLC (Direct Owner)	151 Farmington Drive Hartford, CT 06156	30-0123754
David McNichols Principal Officer - President	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A
Edward C. Lee Principal Officer – Vice President & Assistant Secretary	151 Farmington Drive Hartford, CT 06156	N/A
Tracy L. Smith Principal Officer – Vice President & Treasurer	200 Highland Corporate Dr. Cumberland, RI 02864	N/A
David P. Delaney Principal Officer – Chief Financial Officer	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A
Robert M. Kessler Principal Officer – Secretary	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A

[8] Please refer to **Appendix A** for a complete listing of office locations for CVS Health Corporation and Aetna Inc.

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

We have included the Tax Identification number for each corporation with an ownership or control interest in Aetna Medicaid Administrators in **Table 3.1.2-5** in response to the question immediately preceding this one. Please note there are no subcontractors in which Aetna Medicaid Administrators has a five (5) percent or more ownership or control interest.

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

In **Table 3.1.2-6,** we indicate whether a person (individual or corporation) with ownership or control interest in the Subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

Table 3.1.2-6: Relationships Among Persons with Ownership or Control Interest in Aetna Medicaid Administrators

Name	Relationship to other Owners or others with Control Interest
CVS Health Corporation (Ultimate Owner)	CVS Health Corporation is the direct owner of CVS Pharmacy, Inc. and the indirect and ultimate owner of Aetna Inc., Aetna Health Holdings, LLC, and Aetna Medicaid Administrators
CVS Pharmacy, Inc. (Indirect Owner)	CVS Pharmacy, Inc.'s direct parent is CVS Health Corporation. CVS Pharmacy, Inc. is Aetna Inc.'s direct parent and an indirect parent of Aetna Health Holdings, LLC and Aetna Medicaid Administrators.
Aetna Inc. (Indirect Owner)	Aetna Inc.'s ultimate parent Is CVS Health Corporation, and its direct parent is CVS Pharmacy, Inc. Aetna Inc. is the direct parent of Aetna Health Holdings, LLC. and an indirect parent of Aetna Medicaid Administrators.
Aetna Health Holdings, LLC (Direct Owner)	Aetna Inc.'s ultimate parent Is CVS Health Corporation, and its direct parent is CVS Pharmacy, Inc. Aetna Inc. is the direct parent of Aetna Health Holdings, LLC. and an indirect parent of Aetna Medicaid Administrators.
David McNichols	None

Name	Relationship to other Owners or others with Control Interest
Edward C. Lee	None
Tracy L. Smith	None
David P. Delaney	None
Robert M. Kessler	None

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

Aetna Medicaid Administrators provides the following information in accordance with 42 CFR 455.104(b)(3), as applied to Subcontractors[9].

Aetna Inc. and Aetna Health Holdings, LLC

- Aetna Better Health of North Carolina Inc.
- Aetna Better Health of California Inc.
- Aetna Better Health of Florida Inc.
- Aetna Better Health Inc., an Illinois Corporation dba Aetna Better Health of Illinois
- IlliniCare Health Plan, Inc.
- Aetna Better Health of Kansas Inc.
- Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky
- Aetna Better Health, Inc., a Louisiana Corporation dba Aetna Better Health of Louisiana
- Aetna Better Health of Michigan Inc.
- Aetna Better Health Inc., a New Jersey Corporation dba Aetna Better Health of New Jersey
- Aetna Better Health Inc., a New York Corporation dba Aetna Better Health of New York
- Aetna Better Health Inc., an Ohio Corporation dba Aetna Better Health of Ohio
- Aetna Better Health Inc., a Pennsylvania Corporation dba Aetna Better Health of Pennsylvania
- Aetna Health Inc., a Pennsylvania Corporation dba Aetna Better Health Kids
- Aetna Better Health of Texas Inc.
- Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia
- Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia
- Aetna Health of California Inc.

[9] The sentence immediately preceding the RFP questions requesting ownership and controlling interest information instructs Subcontractors to "provide the [requested] information in accordance with 42 CFR §455.104." Please refer to RFP page 60. The requirement in 42 CFR 455.104(b)(3) appears to most closely mirror what is requested here. As worded, however, this RFP request is broader than what is required by 42 CFR 455 104(b)(3), which if re-worded to apply to Subcontractors would require disclosure of "the name of any other disclosing entity (or fiscal agency or managed care entity) in which an owner of the [Subcontractor] (or fiscal agent or managed care entity) has an ownership interest." Applying the instruction on page 60, the information we provided in response to this request is in accordance with what is requested in 42 CFR §455.104(b)(3), as reworded to apply to Subcontractors. If the Department disagrees with our approach or seeks what appears to be the broader information requested here, we will provide additional information upon request.

- Aetna Health Inc., a Georgia Corporation
- Coventry Health and Life Insurance Company
- Aetna Health of Iowa Inc. d/b/a Coventry Health Care of Iowa, Inc.
- Coventry Health Care of Missouri, Inc. dba Care Management Resources (fictitious name: Coventry Health Care)
- Aetna Health Inc., a New Jersey Corporation
- Allina Health and Aetna Insurance Company
- Aetna Health Inc., a New York Corporation
- Aetna Health Inc., a Maine Corporation
- Aetna Health Inc., a Louisiana Corporation d/b/a Coventry Health Care of Louisiana, Inc.
- Aetna Health Inc., a Pennsylvania Corporation
- Aetna Health Inc., a Pennsylvania Corporation d/b/a HealthAmerica Pennsylvania
- Aetna Health Inc., a Texas Corporation
- Aetna Health Inc., a Georgia Corporation d/b/a Coventry Health Care of Georgia, Inc.
- Coventry Health Care of Kansas, Inc.
- Aetna Life Insurance Company
- HealthAssurance Pennsylvania, Inc.
- Aetna Health Inc., a Connecticut Corporation
- Coventry Health Care of Nebraska, Inc. d/b/a Aetna Health Better Health of Nebraska
- Coventry Health Care of Illinois, Inc.
- Aetna Health of Utah Inc. d/b/a Altius Health Plans Inc.
- First Health Life & Health Insurance Company
- Innovation Health Insurance Company
- Innovation Health Plan, Inc.
- Aetna Dental Inc., a New Jersey Corporation
- Aetna Dental Inc., a Texas Corporation
- Aetna Dental of California Inc.
- Aetna Health and Life Insurance Company
- Aetna Health Inc., a Florida Corporation
- Aetna Health Inc., a Louisiana Corporation
- Aetna Health Inc., a Pennsylvania Corporation d/b/a Aetna Better Health of Maryland
- Aetna Health Inc., a Michigan Corporation
- Aetna Health Insurance Company
- Aetna Health Insurance Company of New York
- Aetna Health of Iowa Inc.
- Aetna Health of Utah Inc.
- Aetna HealthAssurance Pennsylvania, Inc.
- American Continental Insurance Company
- Banner Health and Aetna Health Insurance Company
- Banner Health and Aetna Health Plan Inc.
- Continental Life Insurance Company of Brentwood, Tennessee
- Coventry Health Care of Florida, Inc.
- Coventry Health Care of Missouri, Inc.
- Coventry Health Care of Virginia, Inc.
- Coventry Health Care of West Virginia, Inc.

- Coventry Health Plan of Florida, Inc.
- Health and Human Resource Center, Inc.
- MHNet Life and Health Insurance Company
- Texas Health + Aetna Health Insurance Company
- Texas Health + Aetna Health Plan Inc.

CVS Health Corporation

- CVS Pharmacy, Inc.

CVS Pharmacy, Inc.[10]

- Alabama CVS Pharmacy, L.L.C.
- Alaska CVS Pharmacy, L.L.C.
- American Drug Stores Delaware, L.L.C.
- Arizona CVS Stores, L.L.C.
- Arkansas CVS Pharmacy, L.L.C.
- Busse CVS, L.L.C.
- CareCenter Pharmacy, L.L.C.
- Caremark Rx, L.L.C.
- Connecticut CVS Pharmacy, L.L.C.
- CVS 2948 Henderson, L.L.C.
- CVS 3268 Gilbert, L.L.C.
- CVS 3745 Peoria, L.L.C.
- CVS Albany, L.L.C.
- CVS Bellmore Avenue, L.L.C.
- CVS Gilbert 3272, L.L.C.
- CVS Manchester NH, L.L.C.
- CVS NV Holding Company, L.L.C.
- CVS PR Center, Inc
- CVS PR Holding Company, L.L.C.
- CVS RS Arizona, L.L.C.
- CVS Rx Services, Inc.
- CVS State Capital, L.L.C.
- D.A.W., L.L.C.
- Delaware CVS Pharmacy, L.L.C.
- District of Columbia CVS Pharmacy, L.L.C.
- Garfield Beach CVS, L.L.C.
- Georgia CVS Pharmacy, L.L.C.
- German Dobson CVS, L.L.C.
- Goodyear CVS, L.L.C.
- Grand St. Paul CVS, L.L.C.
- Highland Park CVS, L.L.C.
- Holiday CVS, L.L.C.

[10] These entities and their subsidiaries operate over 10,000 retail pharmacy, LTC pharmacy, mail service pharmacy, specialty pharmacy, PDP, infusion provider and clinical provider locations. Detailed information is available upon request.

- Hook-SupeRX, L.L.C.
- Idaho CVS Pharmacy, L.L.C.
- Iowa CVS Pharmacy, L.L.C.
- Kansas CVS Pharmacy, L.L.C.
- Kentucky CVS Pharmacy, L.L.C.
- Longs Drug Stores California, L.L.C.
- Longs Drug Stores, L.L.C.
- Louisiana CVS Pharmacy, L.L.C.
- Maryland CVS Pharmacy, L.L.C.
- Melville Realty Company, Inc.
- MinuteClinic, L.L.C.
- Mississippi CVS Pharmacy, L.L.C.
- Missouri CVS Pharmacy, L.L.C.
- Montana CVS Pharmacy, L.L.C.
- Nebraska CVS Pharmacy, L.L.C.
- Nevada CVS Pharmacy, L.L.C.
- New Jersey CVS Pharmacy, L.L.C.
- North Carolina CVS Pharmacy, L.L.C.
- Ohio CVS Stores, L.L.C.
- Oklahoma CVS Pharmacy, L.L.C.
- Omnicare, Inc.
- Oregon CVS Pharmacy, L.L.C.
- Pennsylvania CVS Pharmacy, L.L.C.
- ProCare Pharmacy, L.L.C.
- Puerto Rico CVS Pharmacy, L.L.C.
- Rhode Island CVS Pharmacy, L.L.C.
- Sheffield Avenue CVS, L.L.C.
- South Carolina CVS Pharmacy, L.L.C.
- South Wabash CVS, L.L.C.
- Tennessee CVS Pharmacy, L.L.C.
- Thomas Phoenix CVS, L.L.C.
- Utah CVS Pharmacy, L.L.C.
- Vermont CVS Pharmacy, L.L.C.
- Virginia CVS Pharmacy, L.L.C.
- Warm Springs Road CVS, L.L.C.
- Washington CVS Pharmacy, L.L.C.
- Washington Lamb CVS, L.L.C.
- West Virginia CVS Pharmacy, L.L.C.
- Wisconsin CVS Pharmacy, L.L.C.
- Woodward Detroit CVS, L.L.C

Center for the Study of Services

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Center for the Study of Services
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	52-1000466
Industry (NAICS)	518210
Type of Legal Entity	Non-profit corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Nonprofit Corporation
Number of Full-Time Employees	55
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	17,066,538
Last Fiscal Year Company Net Income	909,263
% of Revenue From State Government Clients in the United States	12%
Number of Years in Business	45
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	26
Number of Employees Providing the Type of Services Specified in the RFP	26
Headquarters in the United States	1625 K Street, NW Suite 800, Washington, DC 20006
Headquarters Mailing Address	1625 K Street, NW Suite 800, Washington, DC 20006
Street Address	1625 K Street, NW Suite 800, Washington, DC 20006
Telephone Number	(202) 347-9612
Fax Number	(202) 347-4000
Locations in the United States	Washington, DC
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** same as above **Mailing Address:** same as above **Street Address:** same as above **Telephone Number:** same as above

Subcontractor Overview	
	Fax Number: same as above
Name of Contact Person for Bid	Eban Lewis

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

We have included the requested information in **Table 3.1.2-7** for any person (individual or corporation) with an ownership or control interest in the Subcontractor.

Table 3.1.2-7: Name and Address of Any Person (Individual or Corporation) with an Ownership or Control Interest in Center for the Study of Services

Name	Address
Robert Krughoff (President, Director)	1625 K Street, NW Suite 800, Washington, DC 20006
Randy Swisher (Secretary/Treasurer)	1236 Pinecrest Circle, Silver Spring, MD 20910
Tod Herbers (Chairman, Director)	451 Hungerford Drive, Rockville, MD 20850
Robert Stumberg	600 New Jersey Ave, NW, Washington, DC 20001
Katrinka Sloan	2519 Connecticut Ave, NW, Washington, DC 20008
Stephen Brobeck	620 I Street, NW #200, Washington, DC 20006

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

N/A

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Change Healthcare Solutions, LLC

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Change Healthcare Solutions, LLC
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	20-5716594
Industry (NAICS)	Healthcare Technology
Type of Legal Entity	Limited liability company
Company Ownership (e.g., Private/Public, Joint Venture)	Public
Number of Full-Time Employees	Approximately 15,000
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$3.0 billion
Last Fiscal Year Company Net Income	$192.4 million
% of Revenue From State Government Clients in the United States	Change Healthcare's Payer client base is comprised of approximately 15% Blues and Government Payer entities.
Number of Years in Business	25+
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	Change Healthcare has been a solutions partner with Aetna Corporate, Aetna Medicaid and its affiliated health plans over twenty years, providing a variety of health care technology solutions across the continuum of care. CHC is in a constant state of developing and deploying new technologies and tool sets to increase efficiency, decrease cost, and enhance the user experience for our clients. This business is currently covered under an enterprise-wide agreement with Aetna.
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 15 employees directly supporting day-to day oversight of Change Healthcare solutions with the Aetna Medicaid organization. Behind the scenes operations and technical support include substantially more employees, but not in sole support of the Aetna Medicaid organization.
Headquarters in the United States	Nashville, TN
Headquarters Mailing Address	3055 Lebanon Pike, Suite 1000, Nashville, TN 37214
Street Address	3055 Lebanon Pike, Suite 1000, Nashville, TN 37214
Telephone Number	(615) 932-3000

Subcontractor Overview	
Fax Number	
Locations in the United States	3055 Lebanon Pike, Suite 1000, Nashville, TN 37214 13209 Corporate Exchange Drive, Bridgeton, MO 63044
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** same as above **Mailing Address:** same as above **Street Address:** same as above **Telephone Number:** same as above **Fax Number:** same as above
Name of Contact Person for Bid	Ann Armstrong

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Change Healthcare, LLC has locations at 3055 Lebanon Pike, Suite 1000, Nashville, TN 37214

and 13209 Corporate Exchange Drive, Bridgeton, MO 63044.

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

Federal Tax ID 20-5716594

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Cotiviti, Inc.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Cotiviti, Inc. (representing itself and its subsidiaries and affiliates)
Name of Parent Company (If Applicable)	Verscend Holding Corp
Tax Identification Number	56-2059380
Industry (NAICS)	541611
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	Cotiviti has more than 5,000 employees.
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$644,999 ($ in thousands)
Last Fiscal Year Company Net Income	$163,247 ($ in thousands)
% of Revenue From State Government Clients in the United States	Less than one percent.
Number of Years in Business	The businesses that ultimately formed the company that Cotiviti is today have been in business for varying amounts of time, with the oldest being close to 40 years old and most averaging in the 15- to 20-year range. The original company, Verisk Health, was formed in 2004 based on a series of acquisitions. The company was rebranded to Verscend Technologies in 2016 after it was sold by Verisk Analytics. We became Cotiviti, Inc., upon its acquisition of Cotiviti Holdings in 2018. Cotiviti Holdings was founded as Connolly in 1979 as a provider of payment accuracy solutions to the retail industry and launched retrospective claims accuracy solutions to the health care industry in 1998.
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	Our legacy companies have been providing health care analytic services for over 20 years.
Number of Employees Providing the Type of Services Specified in the RFP	Variable depending on the project scope.
Headquarters in the United States	Atlanta, GA
Headquarters Mailing Address	One Glenlake Parkway, Suite 1400, Atlanta, GA 30328

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

Subcontractor Overview	
Street Address	One Glenlake Parkway, Suite 1400, Atlanta, GA 30328
Telephone Number	770-379-2800
Fax Number	470-385-3641
Locations in the United States	Cotiviti has numerous locations nationally, including Waltham, MA; Atlanta, GA; Wilton, CT; South Jordan, UT; and Blue Bell, PA, in addition to many smaller offices across the country.
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** same as above **Mailing Address:** same as above **Street Address:** same as above **Telephone Number:** same as above **Fax Number:** same as above
Name of Contact Person for Bid	Susan Murray

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Verscend Holding Corp, 201 Jones Road 4th Floor Waltham, MA 02451 United States

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

Verscend Holding Corp, Tax ID 81-2506127

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

CQ fluency, Inc.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	CQ fluency, Inc.
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	32-0102982
Industry (NAICS)	541930
Type of Legal Entity	S Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	74
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$14,500,000
Last Fiscal Year Company Net Income	$14,500,000
% of Revenue From State Government Clients in the United States	10%
Number of Years in Business	20
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	20
Number of Employees Providing the Type of Services Specified in the RFP	51
Headquarters in the United States	Yes
Headquarters Mailing Address	2 University Plaza Dr, Suite 406, Hackensack, NJ 07601
Street Address	2 University Plaza Dr, Suite 406, Hackensack, NJ 07601
Telephone Number	201-487-8007
Fax Number	201-487-8052
Locations in the United States	New Jersey
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** same as above **Mailing Address:** same as above **Street Address:** same as above **Telephone Number:** same as above

Subcontractor Overview	
	Fax Number: same as above
Name of Contact Person for Bid	Alan Vernon

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Elisabete Miranda, 2 University Plaza Dr., Suite 406, Hackensack, NJ 07601

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

N/A

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Equian, LLC

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Equian, LLC
Name of Parent Company (If Applicable)	Equian Buyer Corp.
Tax Identification Number	27-0083277
Industry (NAICS)	Health care
Type of Legal Entity	LLC
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	1,900
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$420,526,132
Last Fiscal Year Company Net Income	$61,392,208
% of Revenue From State Government Clients in the United States	Less than 5% of Equian's annual revenue is from State Government clients in the United States.
Number of Years in Business	15
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	Through acquisitions, Equian has been performing subrogation services for 30 years and itemized bill review for 14 years.
Number of Employees Providing the Type of Services Specified in the RFP	There are 768 employees providing subrogation services and 130 employees providing itemized bill review services.
Headquarters in the United States	Yes
Headquarters Mailing Address	5975 Castle Creek Parkway, Suite 100, Indianapolis, IN 46250
Street Address	5975 Castle Creek Parkway, Suite 100, Indianapolis, IN 46250
Telephone Number	800-962-6831
Fax Number	N/A
Locations in the United States	Equian offices: Headquarters: 5975 Castle Creek Parkway, Indianapolis IN 46250; Other US Locations: 7480 Halcyon Pointe Drive, Suite 300, Montgomery AL 36117 600 12th Street, Suite 300, Golden CO 80401

Subcontractor Overview	
	101 Merritt Street, Suite 300, Norwalk CT 06851 2600 Westown Parkway, Suite 250, West Des Moines IA 50266 1000 Warrenville Road, Suite 200, Naperville IL 60563 9390 Bunsen Parkway, Louisville KY 40220 7101 Wisconsin Avenue, Suite 1050, Bethesda MD 20814 500 Unicorn Park, Woburn MA 01801 26555 Evergreen Road, Suite 200, Southfield MI 48076 134 Pleasant Street, Portsmouth NH 03801 2448 East 81st Street, Tulsa OK 74137 1010 Western Avenue, Pittsburgh PA 15233 381 Riverside Drive #300, Franklin TN 37064 1101 N. Old World Third Street, Milwaukee WI 53203"
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** Equian **Mailing Address:** 5975 Castle Creek Parkway, Suite 100, Indianapolis, IN 46250 **Street Address:** 5975 Castle Creek Parkway, Suite 100, Indianapolis, IN 46250 **Telephone Number:** 800-962-6831 **Fax Number:** N/A
Name of Contact Person for Bid	Stephanie Elliott

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

"Equian Parent Corp., 5975 Castle Creek Parkway, Suite 100, Indianapolis IN 46250"

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

27-0083277

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

eviCore healthcare MSI, LLC

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	eviCore healthcare MSI, LLC d/b/a eviCore healthcare (f/k/a MedSolutions, Inc.)
Name of Parent Company (If Applicable)	Cigna Corporation (NYSE: CI)
Tax Identification Number	62-1615395
Industry (NAICS)	541511
Type of Legal Entity	Limited liability company
Company Ownership (e.g., Private/Public, Joint Venture)	Subsidiary of a public company
Number of Full-Time Employees	More than 5,000 employees
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	FY18: $2.75B
Last Fiscal Year Company Net Income	FY18: $67.4M
% of Revenue From State Government Clients in the United States	19%
Number of Years in Business	25 years (July 28, 1995)
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	25 years
Number of Employees Providing the Type of Services Specified in the RFP	eviCore healthcare has more than 5,000 total employees. Our expanded utilization management staff and contact center representatives includes approximately 2,400 in total including more than 300 medical directors, 800 nurses, and 1,300 contact center representatives.
Headquarters in the United States	Yes. eviCore healthcare is headquartered in South Carolina.
Headquarters Mailing Address	400 Buckwalter Place Blvd., Bluffton, SC 29910
Street Address	400 Buckwalter Place Blvd., Bluffton, SC 29910
Telephone Number	800-918-8924
Fax Number	866-699-8160
Locations in the United States	eviCore has eight office locations across the continental United States. Below is a full list of office locations, detailing headquarters,

Subcontractor Overview	
	and contact center presence: • Bluffton, South Carolina • Boston, Massachusetts • Colorado Springs, Colorado • Franklin, Tennessee • Melbourne, Florida • Plainville, Connecticut • St. Louis, Missouri • West Seneca, New York eviCore also has remote employees throughout the United States. eviCore's Operations Centers are 100% voice, data, and application redundant across geographically diverse critical-reliability data centers. This ensures 100% availability of eviCore services. By using a next-in-queue call center environment, all incoming calls route to the next available eviCore agent, regardless of location. This structure offers multisite redundancy, appropriate staff resourcing, and call-load balancing during peak call center requests.
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Name: Patrick Dawson Mailing Address: 400 Buckwalter Place Blvd., Bluffton, SC 29910 Street Address: 400 Buckwalter Place Blvd., Bluffton, SC 29910 Telephone Number: 800-918-8924 Fax Number: 866-699-8160
Name of Contact Person for Bid	Patrick Dawson

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

eviCore healthcare MSI, LLC (eviCore) is a fully owned subsidiary of Cigna Corporation (NYSE: CI) (Cigna), a publicly held entity with offices located at 900 Cottage Grove Road, Bloomfield, CT 06002.

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

Cigna Corporation's tax identification number is 82-4991898

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

eviCore healthcare MSI, LLC (eviCore) is a fully owned subsidiary of Cigna Corporation (NYSE: CI) (Cigna), a publicly held entity. Information regarding Cigna's ownership of other entities is publicly available through the Cigna and SEC websites.

First Choice Services, Inc.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	First Choice Services, Inc.
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	26-2900507
Industry (NAICS)	All other support services (561990)
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private Non-Profit
Number of Full-Time Employees	54
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$4,000,000
Last Fiscal Year Company Net Income	182,665
% of Revenue From State Government Clients in the United States	90%
Number of Years in Business	15
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	2
Number of Employees Providing the Type of Services Specified in the RFP	10
Headquarters in the United States	Yes
Headquarters Mailing Address	First Choice Services, Inc.
Street Address	601 Morris Street Suite 401, Charleston, WV 25301
Telephone Number	304-400-4802
Fax Number	304-356-5845
Locations in the United States	N/A
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** same as above **Mailing Address:** same as above **Street Address:** same as above **Telephone Number:** same as above

Subcontractor Overview	
	Fax Number: same as above
Name of Contact Person for Bid	Judy Akers

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

N/A

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

N/A

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Health Management Systems, Inc.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Health Management Systems, Inc.
Name of Parent Company (If Applicable)	HMS Holdings Corp.
Tax Identification Number	13-2770433
Industry (NAICS)	541511
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	Approximately 2,500
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$435,245,026
Last Fiscal Year Company Net Income	$92,933,182
% of Revenue From State Government Clients in the United States	51%
Number of Years in Business	Approximately 45
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	HMS has been providing coordination of benefits reclamation billing services to Medicaid managed care organizations for approximately 45 years.
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 100
Headquarters in the United States	Yes
Headquarters Mailing Address	5615 High Point Dr., Irving, TX 75038
Street Address	5615 High Point Dr., Irving, TX 75038
Telephone Number	214-435-3000
Fax Number	212-857-5010
Locations in the United States	Currently HMS has 27 offices: Albany, NY; Anchorage, AK; Atlanta, GA; Baltimore, MD; Boise, ID; Charleston, WV; Charlestown, MA; Danvers, MA; Englewood, CO; Longmont, CO; Hamilton, NJ; Irvine, CA; Irving, TX; Jackson, MS; Blue Springs, MO; Las Vegas, NV; Montgomery, AL; New York, NY; Omaha, NE; Phoenix, AZ; Raleigh,

Subcontractor Overview	
	NC; Reno, NV; Sacramento, CA; Topeka, KS; Washington, DC; Westerville, OH; Windsor, CT
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** Taylor Culberson **Mailing Address:** 5615 High Point Dr., Irving, TX 75038 **Street Address:** 5615 High Point Dr., Irving, TX 75038 **Telephone Number:** 469-346-9985 **Fax Number:** 212-857-5010
Name of Contact Person for Bid	Taylor Culberson, Account Director

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

We have included the requested information in **Table 3.1.2-8** for any person (individual or corporation) with an ownership or control interest in the Subcontractor.

Table 3.1.2-8: Name and Address of Any Person (Individual or Corporation) with an Ownership or Control Interest in Health Management Systems, Inc.

Name	Title	Address	TIN	% Ownership Interest
Individuals				
Lucia, William C.	Director, President & Chief Executive Officer	5615 High Point Drive, Irving, TX 75038	N/A	0%
Alexander, David	SVP, Chief Human Resources and Chief Compliance Officer	5615 High Point Drive, Irving, TX 75038	N/A	0%
Aunan, Greg D	SVP, Chief Accounting Officer	5615 High Point Drive, Irving, TX 75038	N/A	0%

Name	Title	Address	TIN	% Ownership Interest
Bjorck, Meredith W.	EVP, Chief Legal Officer & Corporate Secretary	5615 High Point Drive, Irving, TX 75038	N/A	0%
O'Gara, Emmet	Group President, Population Health Management	75 Sylvan Street, Danvers, MA	N/A	0%
Perrin, Maria	EVP, Chief Marketing and Strategy Officer	5615 High Point Drive, Irving, TX 75038	N/A	0%
Sherman, Jeffrey S.	Director, EVP, Chief Financial Officer & Treasurer	5615 High Point Drive, Irving, TX 75038	N/A	0%
Sims, Jacob	SVP, Chief Technology Officer	5615 High Point Drive, Irving, TX 75038	N/A	0%
South, Tracy A.	EVP, Chief Administrative Officer	5615 High Point Drive, Irving, TX 75038	N/A	0%
Williams Jr., Douglas M.	EVP, Chief Operating Officer	5615 High Point Drive, Irving, TX 75038	N/A	0%
Entities				
HMS Holdings Corp.[11]	Direct Owner	5615 High Point Drive, Irving, TX 75038	11-3656261	100%
BlackRock, Inc.[12]	Indirect Owner	55 East 52nd St., New York, NY 10022	32-0174431	14.80%

[11] Health Management Systems, Inc. became a wholly owned subsidiary of HMS Holdings Corp. in March 2003 when HMS Holdings Corp. assumed its business in connection with the adoption of a holding company structure.
[12] Based solely on a Schedule 13G/A filed with the SEC on January 28, 2019. Information reported is as of December 31, 2018.

Name	Title	Address	TIN	% Ownership Interest
Wellington Management Group LLP and affiliated entities[13]	Indirect Owner	280 Congress Street, Boston, MA 02210	04-2683227	10.17%
The Vanguard Group[14]	Indirect Owner	100 Vanguard Blvd., Malvern, PA 19355	23-1945930	10.26%

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

We have included the Tax Identification Number for each corporation with an ownership or control interest in Health Management Systems, Inc. in **Table 3.1.2-8** in response to the question immediately preceding this one.

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

- HMS Holdings Corp.
- IntegriGuard, LLC, d/b/a HMS Federal
- Permedion, Inc.
- HealthDataInsights, Inc.
- Reimbursement Services Group Inc.
- Essette, Inc.
- Eliza Corporation

[13] Based solely on a Schedule 13G/A filed with the SEC on March 11, 2019. Information reported is as of February 28, 2019.
[14] Based solely on a Schedule 13G/A filed with the SEC on February 12, 2019. Information reported is as of December 31, 2018.

Inovalon, Inc.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Inovalon, Inc.
Name of Parent Company (If Applicable)	Inovalon Holdings, Inc.
Tax Identification Number	71-1017974
Industry (NAICS)	541690 – Other Scientific and Technical Coding Services 511210 – Software Publishers 518210 – Data Processing, Hosting and Related Services 541511 – Custom Computer Programming Services
Type of Legal Entity	Inovalon, Inc. is a Delaware C-Corporation.
Company Ownership (e.g., Private/Public, Joint Venture)	All of Inovalon, Inc. is a wholly owned subsidiary of Inovalon Holdings, Inc., a public company (INOV: NASDAQ) whose public filings can be found at http://www.sec.gov and http://investors.inovalon.com/.
Number of Full-Time Employees	Inovalon employs over 2,500 employees.
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	2018 gross revenue was $527,676 (in thousands). Forecast gross sales revenue for 2019: our full year guidance range is $638M-$648M.
Last Fiscal Year Company Net Income	2018 new revenue was $382.9 (in thousands)
% of Revenue From State Government Clients in the United States	Inovalon does not have any state government clients.
Number of Years in Business	21 years. Inovalon and its predecessor companies have been operating since 1998.
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	Inovalon, Inc. provides complete administrative and hybrid rate reporting services in support of Aetna's National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)® submission process. As an NCQA-certified vendor for the past 18 years, Inovalon's experienced teams will support the Aetna Medicaid organization team as they complete the key milestones and tasks associated with the HEDIS® reporting requirements using Inovalon's quality measurement and reporting software. Production tasks included data transformation and loading, building events and discharges, running preliminary rates, generation of the Consumer Assessment of Healthcare Providers and Systems/ Qualified Health Plan survey sample frames, sampling of the hybrid measures, calculation of interim and final rates, assisting the plan with the HEDIS® Compliance Audit, as well as submissions to NCQA, Centers for Medicare & Medicaid Services, and other regulatory

Subcontractor Overview	
	agencies. In support of Aetna's state regulatory reporting requirements, Inovalon creates and maintains multiple, custom, state measure catalogs, outside of the standard HEDIS® measure set. In addition to Aetna, Inovalon has worked collaboratively with hundreds of plans to ensure that each client-specific reporting requirement is fulfilled. Aetna's HEDIS® project(s) are managed in a client cloud access model within Inovalon's vendor-controlled environment. In this option, the health plan pushes its data onto Inovalon servers through a secure connection where Aetna's teams are responsible for all aspects of the rate production. Inovalon maintains the hardware and software infrastructure, as well as the storage capacity necessary to host the project. All software upgrades and system backups are Inovalon's responsibility.
Number of Employees Providing the Type of Services Specified in the RFP	Two products service managers will cover the types of services covered under the RFP.
Headquarters in the United States	Yes. Inovalon Inc. is headquartered in the United States.
Headquarters Mailing Address	4321 Collington Road, Bowie, MD 20716
Street Address	4321 Collington Road, Bowie, MD 20716
Telephone Number	(301) 809-4000
Fax Number	(301) 809-4040
Locations in the United States	Inovalon office locations are: • Atlanta, GA: Technology • Bowie, MD: Headquarters • Canonsburg, PA: Creehan & Company Corporation, an Inovalon Company • Reston, VA: Technology • Phoenix, AZ: Operations • Washington, DC: Avalere Health, an Inovalon Company • Nashville, TN: ComplexCare Solutions, an Inovalon Company
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** Bill Carden, Senior Director and General Manager, Quality Spectrum® **Mailing Address:** 4321 Collington Rd., Bowie, MD 20716 **Street Address:** 4321 Collington Rd., Bowie, MD 20716 **Telephone Number:** (301) 809-4000 ext. 6162 **Fax Number:** 301-809-4040
Name of Contact Person for Bid	Bill Carden, Senior Director and General Manager, Quality Spectrum®

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Inovalon, Inc. is a wholly owned subsidiary of Inovalon Holdings, Inc., a public company (INOV: NASDAQ) whose public filings can be found at http://www.sec.gov and http://investors.inovalon.com/. The address is 4321 Collington Road, Bowie, MD 20716.

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

47-1830316

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

MCMC, LLC

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	MCMC, LLC
Name of Parent Company (If Applicable)	CareWorks Managed Care Services, Inc.
Tax Identification Number	14-1847542
Industry (NAICS)	Managed care services. 524298 (all other insurance-related)
Type of Legal Entity	Limited liability company
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	120
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$25,500,000
Last Fiscal Year Company Net Income	$7,100,000 (EBITDA not net Income)
% of Revenue From State Government Clients in the United States	8–10% of revenue
Number of Years in Business	17 years
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	17 years
Number of Employees Providing the Type of Services Specified in the RFP	120
Headquarters in the United States	Yes
Headquarters Mailing Address	300 Crown Colony Drive, Suite 203, Quincy, MA 02169
Street Address	300 Crown Colony Drive, Suite 203, Quincy, MA 02169
Telephone Number	617-375-7700
Fax Number	617-375-7777
Locations in the United States	Location include: 300 Crown Colony Drive, Suite 203, Quincy, MA 02169; Corporate Woods 55, 9300 West 110th Street; Overland Park, KS 66210; 5272 River Road, #650, Bethesda, MD 20816; and 10200 49th St. North, Suite 100 Clearwater, FL 33762

Subcontractor Overview	
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** MCMC, LLC **Mailing Address:** 300 Crown Colony Drive, Suite 203, Quincy, MA 02169 **Street Address:** Same as above. **Telephone Number:** 617-375-7700 **Fax Number:** 617-375-7777
Name of Contact Person for Bid	Darren Rollins

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

CareWorks Managed Care Services, Inc., 405 Duke Drive, Suite 270, Franklin, TN 37067

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

74-2760720

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

MCMC Independent Exams, LLC and CompEval DD Exams, LLC

NantHealth

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	NantHealth, Inc.
Name of Parent Company (If Applicable)	Nantworks
Tax Identification Number	27-3019889
Industry (NAICS)	Healthcare
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	In June 2016 NantHealth, Inc., went public and began trading on the NASDAQ Stock Exchange under the symbol NH
Number of Full-Time Employees	398
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$89.5 million
Last Fiscal Year Company Net Income	($192 million)
% of Revenue From State Government Clients in the United States	$603K
Number of Years in Business	NantHealth was founded in 2007 Eviti was found in 2003
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	Eviti has been doing business since 2003
Number of Employees Providing the Type of Services Specified in the RFP	76
Headquarters in the United States	Yes
Headquarters Mailing Address	NantHealth headquarters is located at 9920 Jefferson Boulevard, Culver City, California 90232
Street Address	9920 Jefferson Boulevard
Telephone Number	(855) 949-6268

Subcontractor Overview	
Fax Number	
Locations in the United States	CA, MA, PA
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	1735 Market Street, Ste. 1300 Philadelphia, PA 19103 (855) 949-6268
Name of Contact Person for Bid	Anne Donovan

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

NantWorks, LLC, 9920 Jefferson Boulevard, Culver City, California 90232

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

36-4694712

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

Patrick Soon-Shiong is the owner of NantWorks, LLC

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

NantWorks, LLC is a majority owner of:

- NantKwest, Inc.
- ImmunityBio, Inc.
- NantOmics, LLC.
- Prest & Associates, LLC

Prest & Associates, LLC

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Prest & Associates, LLC
Name of Parent Company (If Applicable)	ExamWorks, LLC
Tax Identification Number	61-1852481
Industry (NAICS)	Independent Review Organization
Type of Legal Entity	Limited Liability Company
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	22
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	For 2018 the total revenue for EW was $1,269,668,000.
Last Fiscal Year Company Net Income	The net income in 2018 was $222,218,000.
% of Revenue From State Government Clients in the United States	Less than 5 percent.
Number of Years in Business	28
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	28
Number of Employees Providing the Type of Services Specified in the RFP	22
Headquarters in the United States	Yes
Headquarters Mailing Address	401 Charmany Dr. , Suite 305 Madison, WI 53719
Street Address	Same as above.
Telephone Number	(800) 358-5129
Fax Number	(608) 232-9929

Subcontractor Overview	
Locations in the United States	1 – Madison, Wisconsin
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Same as above.
Name of Contact Person for Bid	Judith Shaffer, General Manager

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

ExamWorks, LLC, 3280 Peachtree Road #2625, Atlanta, GA 30305

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

26-1114252

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

SKYGEN USA, LLC

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	SKYGEN USA, LLC
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	81-0762694
Industry (NAICS)	524292
Type of Legal Entity	LLC
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	Approximately 600
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$95,594,000
Last Fiscal Year Company Net Income	$6,324,000
% of Revenue From State Government Clients in the United States	3.3%
Number of Years in Business	25
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	25
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 600
Headquarters in the United States	Yes
Headquarters Mailing Address	SKYGEN USA W140 N8981 Lilly Road Menomonee Falls, WI 53051
Street Address	W140 N8981 Lilly Road Menomonee Falls, WI 53051
Telephone Number	262-946-4400
Fax Number	262-347-3219
Locations in the United States	W140 N8981 Lilly Road Menomonee Falls, WI 53051

Subcontractor Overview	
	10201 N. Port Washington Road Mequon, WI 53092 N92 W14612 Anthony Avenue Menomonee Falls, WI 53051 1000 W. Donges Bay Road Mequon, WI 53092
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** same as above **Mailing Address:** same as above **Street Address:** same as above **Telephone Number:** same as above **Fax Number:** same as above
Name of Contact Person for Bid	Mark Dasek

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

We have included the requested information in **Table 3.1.2-9** for any person (individual or corporation) with an ownership or control interest in the Subcontractor.

Table 3.1.2-9: Name, Address, Tax ID Number of Any Person (Individual or Corporation) with an Ownership or Control Interest in SKYGEN USA, LLC

Name	Address	TIN	% Ownership Interest
Grambino Technologies, LLC	W140N89981 Lilly Rd., Menomonee Falls, WI 53051	20-8448188	37.5% ownership interest in SKYGEN USA, LLC
MOA Investments, LLC	W140N89981 Lilly Rd., Menomonee Falls, WI 53051	39-01865244	37.5% ownership interest in SKYGEN USA, LLC
Scion Holdings, Inc.	W140N89981 Lilly Rd., Menomonee Falls, WI 53051	82-3326543	25% ownership interest in SKYGEN USA, LLC

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

We have included the Tax Identification Number for each corporation with an ownership or control interest in SKYGEN USA, LLC in **Table 1.2-9** in response to the question immediately preceding this one.

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Symphony Performance Health, Inc.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Symphony Performance Health, Inc. d/b/a SPH Analytics
Name of Parent Company (If Applicable)	Symphony Performance Health Holdings, Inc
Tax Identification Number	46-4593394
Industry (NAICS)	541511
Type of Legal Entity	Privately held corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	726 employees
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$31.0M (2018)
Last Fiscal Year Company Net Income	$16.7M (2018)
% of Revenue From State Government Clients in the United States	Approximately 20 to 25% - SPH Analytics would consider a "State Government Client" as a Health Plan Client that has a Medicaid line of business. Please note that SPH Analytics has very few state government clients (i.e. State of Kansas, State of Oregon, Etc.) that are not considered Health Plans or Managed Care Organizations.
Number of Years in Business	35+
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	35+
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 625 employees
Headquarters in the United States	Yes
Headquarters Mailing Address	11605 Haynes Bridge Road, Suite 400, Alpharetta, GA 30009
Street Address	11605 Haynes Bridge Road, Suite 400, Alpharetta, GA 30009
Telephone Number	866-460-5681
Fax Number	678-689-0326
Locations in the United States	Alpharetta, GA Duluth, GA

Subcontractor Overview	
	Branford, CT Farmington Hills, MI Fort Worth, TX Arlington, VA
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** SPH Analytics **Mailing Address:** 1965 Evergreen Blvd., Suite 100, Duluth, GA 30096 **Street Address:** 1965 Evergreen Blvd., Suite 100, Duluth, GA 30096 **Telephone Number:** 770-978-3173 **Fax Number:** 770-623-4075
Name of Contact Person for Bid	John DiCesare, Vice President, Sales – Western US

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Symphony Performance Health Holdings, Inc, 11605 Haynes Bridge Road, Suite 400,

Alpharetta, GA 30009

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

46-4600805

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Vision Service Plan Insurance Company

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Vision Service Plan Insurance Company
Name of Parent Company (If Applicable)	Vision Service Plan (VSP)
Tax Identification Number	06-1227840
Industry (NAICS)	39616
Type of Legal Entity	U.S.-based non-for-profit corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private company with no owners, stakeholders, or shareholders
Number of Full-Time Employees	2,600
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$5.6 Billion
Last Fiscal Year Company Net Income	$161 Million
% of Revenue From State Government Clients in the United States	9.04%
Number of Years in Business	63 years
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	63 years 25 years of managing Medicaid business
Number of Employees Providing the Type of Services Specified in the RFP	2,600
Headquarters in the United States	Rancho Cordova, California
Headquarters Mailing Address	3333 Quality Drive, Rancho Cordova, CA 95670
Street Address	3333 Quality Drive, Rancho Cordova, CA 95670
Telephone Number	800-852-7600
Fax Number	916-463-9002
Locations in the United States	In addition to our corporate headquarters in California and Eastern Operations Center in Ohio, we have 18 regional sales offices across the country to provide local service.
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid	**Name:** same as above **Mailing Address:** same as above

Subcontractor Overview	
(If Different From Above)	**Street Address:** same as above **Telephone Number:** same as above **Fax Number:** same as above
Name of Contact Person for Bid	Larry DeAngelis

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Not Applicable. A U.S.-based not-for-profit corporation, Vision Service Plan (VSP) has no owners, stockholders, or shareholders and is headquartered in California.

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

N/A

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Welltok, Inc.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Welltok, Inc.
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	26-4622137
Industry (NAICS)	511210 Software Publishers
Type of Legal Entity	Welltok is a privately held Delaware C corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	Approximately 430
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	$84,937,000
Last Fiscal Year Company Net Income	As a private company, our financial information is not available for public disclosure.
% of Revenue From State Government Clients in the United States	1.1 percent
Number of Years in Business	Welltok has been in business since 2009.
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	Since 2009
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 430
Headquarters in the United States	Welltok's headquarters is in Denver, CO
Headquarters Mailing Address	Welltok 1515 Arapahoe Street Tower 3, Suite 700 Denver, CO 80202
Street Address	Same as above
Telephone Number	720-502-5200 1 (888) WELLTOK (888-935-5865)
Fax Number	N/A

Subcontractor Overview	
Locations in the United States	In addition to our Denver headquarters, we also have offices Burlington, Massachusetts; Roswell, Georgia; and Newport Beach, California.
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** same as above **Mailing Address:** same as above **Street Address:** same as above **Telephone Number:** same as above **Fax Number:** same as above
Name of Contact Person for Bid	Beth Cappucci, Account Relationship Manager

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

N/A

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

N/A

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

N/A

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

2. Mandatory Qualifications

The Vendor must complete this section to demonstrate that it has the experience needed to meet requirements set forth in this RFP. The table below lists each mandatory qualification; the Vendor must provide narrative demonstrating fulfillment of the requirement and note the page number of its bid that provides this information. The Vendor should provide their response as part of their bid in accordance with the template below. The Vendor must list each project experience separately and completely every time it is referenced. Unless otherwise stated, requested documentation must be provided to the Department as part of the bid submission.

Table 7: Mandatory Qualifications

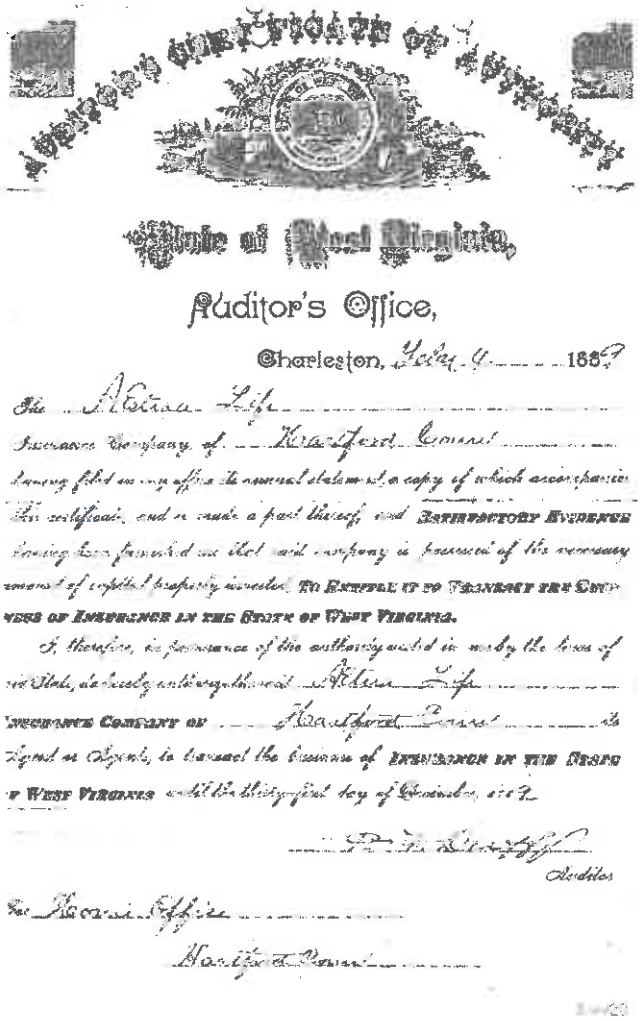
Mandatory Qualification Item(s)	Page Number
The Vendor must demonstrate adherence to Certificate of Authority (COA) requirements as outlined by the West Virginia (WV) Office of the Insurance Commissioner and be in good standing in West Virginia. The Vendor shall provide a copy of its COA as part of its Readiness Review documentation.	**App E-3**
The Vendor must be a NCQA-accredited entity within nine (9) months of the contract effective date, and remain so for the duration of the contract.	**App B-3**
The Vendor must provide an organizational chart outlining the internal organizational structure for this project.	**Att 4 – Page 15**
The Vendor must provide a description of the roles, responsibilities, and skill sets associated with each position outlined in the organizational chart.	**Att 4 – Pages 4-9**
The Vendor must provide a summary description of individual key staff members and the experience that qualifies them for their roles in this project. If any subcontractor is leveraged, the Vendor shall describe the assurance of quality and timeliness of the work to be done.	**Att 4 – Pages 31-73**
The Vendor must demonstrate experience within the last three (3) years as the prime contractor for at least three (3) federal, state, or private healthcare entities, in an MCO, where the proposed solution of similar size and scope is currently being or has been implemented.	**Att 3 - Page 5-18**
The Vendor must demonstrate at least five (5) years' experience in Medicaid.	**Att 3 - Page 5-9**
The Vendor must include at least three (3) references from clients served within the last three (3) years that demonstrate the Vendor's ability to perform the scope of work described in the RFP. Vendors may only use one reference per client served. The Department requests three (3) references from different state engagements where the proposed approach is currently in progress or has been implemented.	**Att 3 - Page 117-127**
The Vendor must have at least three (3) years' experience implementing the proposed approach with an organization similar size and scope to the State, in an MCO capacity.	**Att 3 - Page 19-21**

3. Existing Business Relationships With the State

Describe any existing or recent (within the last five [5] years) business relationships the Vendor or any of its affiliates or proposed subcontractors have with the State, the State's counties, and/or the State's local municipalities. The Vendor should provide their response as part of their bid.

Existing Business Relationships

The Aetna organization has over 160 years of experience as one of the nation's leading diversified health care benefits companies, including 30 years of continuous, active participation in Medicaid managed care. Aetna's deep-rooted history in West Virginia spans over a century, dating to 1889, when our affiliate, Aetna Life Insurance Company, was first granted authority to do business in West Virginia, as depicted in the Certificate of Authority shown in **Figure 3.3.1-1**. Aetna Better Health of West Virginia has provided Medicaid managed care services for the Mountain Health Trust populations since 1996[1] and the West Virginia Health Bridge Medicaid expansion population



State of West Virginia,

Auditor's Office,

Charleston, May 4 1889

The Aetna Life Insurance Company of Hartford Conn. having filed in my office the annual statement a copy of which accompanies this certificate, and is made a part thereof, and SATISFACTORY EVIDENCE having been furnished me that said company is possessed of the necessary amount of capital prescribed by law, to entitle it to transact the business of INSURANCE IN THE STATE OF WEST VIRGINIA.

I, therefore, in pursuance of the authority vested in me by the laws of said State, do hereby authorize the said Aetna Life Insurance Company of Hartford Conn. its Agent or Agents, to transact the business of INSURANCE IN THE STATE OF WEST VIRGINIA until the thirty-first day of January, 1890.

Auditor.

Secretary's Office

Hartford Conn.

Figure 3.3.1-1: Affiliate Aetna Life Insurance Company's 1889 Certificate of Authority

Aetna began proudly serving West Virginians more than 130 years ago.

[1] Aetna Better Health of West Virginia is the dba used by Coventry Health Care of West Virginia, Inc. for its Medicaid line of business. Coventry Health Care of West Virginia, Inc., formerly known as Carelink Health Plans, Inc., has been serving West Virginia's Medicaid population since 1996 and was previously a subsidiary of Coventry Health Care, Inc. (Coventry). In May of 2013, Coventry and all its subsidiaries were acquired by Aetna Inc. On January 1, 2014, Coventry was merged into Aetna Health Holdings LLC. In December of 2015, Coventry Health Care of West Virginia, Inc. began using the dba Aetna Better Health of West Virginia for its Medicaid line of business.

since 2015. We will begin to serve West Virginia's Mountain Health Promise program in the first quarter of 2020.

During our longstanding tenure in West Virginia, Aetna has worked to become an integrated member of communities throughout the State and understand how the unique needs of West Virginians vary from town to town. We know our enrollees, their needs, and communities they live in. We have developed, and continue to evolve, our services to respond to our enrollees' unique needs and their specific conditions, reduce disparities, and build upon our already comprehensive network of high-quality providers and relationships with community-based organizations.

Aetna Better Health of West Virginia's Business Relationships

Coventry Health Care of West Virginia holds contracts with the State in connection with 1) its Medicaid line of business, which utilizes the dba Aetna Better Health of West Virginia, and 2) its Medicare line of business, which does not operate under a dba. These contracts are included in **Table 3.3.1-1.** Coventry Health Care of West Virginia, Inc. has not had any business relationships with any of the State's counties or local municipalities in the last five years.

Table 3.3.1-1: Coventry Health Care of West Virginia, Inc.'s Business Relationships with the State of West Virginia, the State's Counties, and/or the State's Local Municipalities

Entity Name	Client	Tenure in West Virginia	Subject Matter of the Contract
Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia	West Virginia Department of Health and Human Resources	1996 — Present	Medicaid Managed Care Services
Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia	West Virginia Department of Health and Human Resources	1Q 2020 — Present	Specialized Managed Care for Children and Youth

Entity Name	Client	Tenure in West Virginia	Subject Matter of the Contract
Coventry Health Care of West Virginia, Inc.	State of West Virginia Bureau for Medical Services	1/1/2020 – Present	Dual Eligible Special Needs Plan

Aetna Better Health of West Virginia Affiliates' Business Relationships in West Virginia

In **Table 3.3.1-2**, we describe any existing or recent business relationships that any of Aetna Better Health of West Virginia's affiliates have had with the State, the State's counties, and/or the State's local municipalities in the last five years[2].

Table 3.3.1-2: Aetna Better Health of West Virginia Affiliates' Business Relationships with the State of West Virginia, the State's Counties, and/or the State's Local Municipalities

Entity Name	Client	Contract Start and End Date	Subject Matter of the Contract
Aetna Behavioral Health, LLC	West Virginia University Medicine	2015 – Present	Provision of Employee Assistance Program (EAP) services, including a 5-session EAP model, 24/7/365 telephonic consultation, work-life services, employee training, and other related services
Aetna Life Insurance Company	HealthSmart Benefit Solutions and the West Virginia Public Employees Insurance Agency	2015 – 2019	Network access and stop loss for the State of West Virginia employee health program
Aetna Life Insurance Company	West Virginia University	2010 – Present	Student Health Insurance Program
Aetna Life Insurance Company	West Virginia School of Osteopathic Medicine	2017 – Present	Student Health Insurance Program

[2] We understand "business relationships…any…affiliates have with the State, the State's counties, and/or the State's local municipalities" to be limited to contracts such affiliates hold directly with the State of West Virginia, the State's counties, and/or the State's local municipalities. Accordingly, we did not include situations where an affiliate provides subcontracted services to another entity that is contracted with the State, the State's counties, and/or the State's local municipalities. If our understanding of this question is incorrect, we will provide additional information upon request.

Entity Name	Client	Contract Start and End Date	Subject Matter of the Contract
CaremarkPCS Health L.L.C. through its predecessor AdvancePCS Health, L.P.	West Virginia Bureau of Senior Services as assignee to the West Virginia Public Employees Insurance Agency	2001 — Present	Managed Pharmaceutical Benefit Agreement — Consumer Card Program to provide a drug discount card option to retirees
CaremarkPCS Health, L.L.C.	West Virginia Public Employees Insurance Agency (PEIA) and West Virginia Children's Health Insurance Program (CHIP), through a joinder agreement with PEIA	2016 — Present	Pharmacy services; agreement to provide pharmacy benefit management services to State employees and CHIP enrollees
Compass Health Services, LLC dba Omnicare of Morgantown	John D. Good Recovery Center (part of West Virginia University United Summit Center)	2014 — Present	Pharmacy services

In addition to the contracts provided, during the last five years, legacy CVS affiliates have enrolled certain pharmacy locations physically located in the State of West Virginia, as well as a limited number of out-of-state locations, into the West Virginia Medicaid Program. If the Department seeks additional information regarding any of these pharmacy enrollments, we will provide it upon request.

Business Relationships of Aetna Better Health of West Virginia Unaffiliated Proposed Subcontractors[3]

In **Table 3.3.1-3**, we describe any existing or recent business relationships that unaffiliated proposed subcontractors of Aetna Better Health of West Virginia have with the State of West Virginia, its counties, or local municipalities.

Table 3.3.1-3: Aetna Better Health of West Virginia Unaffiliated Proposed Subcontractors' Business Relationships with the State of West Virginia, the State's Counties, and/or the State's Local Municipalities

Entity Name	Client	Contract Term	Subject Matter of the Contract
First Choice Services, Inc. (FCS)	West Virginia Department of Health and Human Resources, Bureau for Behavioral Health and Health Facilities	6/2015-Present	FCS operates the Help4WV line by grant agreement. HELP4WV is a 24/7 resource and referral center designed to streamline the process of seeking help for substance abuse and behavioral health issues. It includes a helpline and chat line. Callers are connected to community-based treatment programs and behavioral health services near them. Most callers are able to enter treatment within one day of calling the helpline. The program features an online public database, of more than 1,000 community resources. FCS answers over 10,000 calls per year from West Virginians seeking assistance through this program.
First Choice Services, Inc. (FCS)	West Virginia Department of Health	7/2017-Present	FCS operates the Tobacco Quitline by grant agreement.

[3] Any business relationships Aetna Better Health of West Virginia's affiliated subcontractors have with the State of West Virginia, its counties, or local municipalities are listed in Table 3.4.1-3 above titled "Aetna Better Health of West Virginia Affiliates' Business Relationships in West Virginia."

Entity Name	Client	Contract Term	Subject Matter of the Contract
	and Human Resources, Bureau for Public Health		The WV Tobacco Quitline is a complete tobacco cessation quit line. Helpline operators refer callers to a coach, counseling, and nicotine replacement therapy help. FCS answers over 11,000 calls per year from West Virginians seeking assistance through this program.
Health Management Systems, Inc.	Department of Health and Human Resources, Bureau for Medical Services	9/1/2011 – 2/29/2020 (renewal possible)	HMS is performing multiple services under our Coordination of Benefits/Third Party Liability workload umbrella. These services may include coverage identification of commercial insurance for Medicaid beneficiaries, retroactive recoveries, Cost-Avoidance, Credit Balance, Disallowance and Workers Compensation subrogation.
Prest & Associates, LLC (PREST)	West Virginia Office of the Insurance Commissioner	2012 – 2018	Internal Review Organization
Vision Service Plan Insurance Company	Child Protect of Mercer County, Inc.	Currently Active	Vision Care Administration
Vision Service Plan Insurance Company	City of Wheeling	Currently Active	Vision Care Administration
Vision Service Plan Insurance Company	Star City Volunteer Fire Department	Currently Active	Vision Care Administration
Vision Service Plan Insurance Company	Wetzel County Committee on Aging	Currently Active	Vision Care Administration
Vision Service Plan Insurance Company	City of Hinton	Ended 11/12016	Vision Care Administration
Vision Service Plan Insurance Company	City of New Martinsville	Ended 10/1/2017	Vision Care Administration

Entity Name	Client	Contract Term	Subject Matter of the Contract
Vision Service Plan Insurance Company	City of Vienna	Ended 7/1/2017	Vision Care Administration
Vision Service Plan Insurance Company	Monongalia County Solid Waste Authority	Ended 12/1/2015	Vision Care Administration
Vision Service Plan Insurance Company	Wayne County Community Services	Ended 7/1/2016	Vision Care Administration
Vision Service Plan Insurance Company	Wetzel County Emergency Ambulance Authority	Ended 8/1/2015	Vision Care Administration

4. Business Disputes

List any regulatory actions, sanctions, citations, deficiencies, audit findings, investigations, contingencies, or recommendations received in any state within the last two (2) years, along with the Vendor's response and plan of correction.

Regulatory Actions

Aetna Better Health of West Virginia strives to be a dependable, transparent, and trusted partner of the Department of Health and Human Resources (Department) in creating solutions to key public health issues. This includes collaborating with stakeholders to design effective policy and achieve the Department's goals, especially the requirements of the contract. From time to time, an Aetna Medicaid organization health plan may receive a notice of action, an important indicator of an opportunity for improvement. Our multidisciplinary approach to identifying, remediating, and monitoring compliance issues is companywide. We perform root-cause analysis and employ the Plan-Do-Study-Act method to address the underlying issues that lead to a notice of action. Results and recommendations are reported to Aetna organization leadership and translated into improved policies and procedures. Aetna is committed to a culture of continuous quality improvement. **We listen. We learn. We take action. We improve.**

Aetna Better Health of West Virginia has not been subject to an investigation within the last two years. Other Medicaid health plans managed by Aetna's Medicaid organization have been subject to the following three investigations[1] in the last two years:

- On September 25, 2017, the Department of Health and Human Services Office of Civil Rights (HHS-OCR) opened an investigation after receiving a complaint alleging that Aetna Better Health of Illinois engaged in unlawful discrimination based on race. On May 22, 2018,

[1] As regulated entities, Aetna Better Health of West Virginia, health plans managed by Aetna's national Medicaid organization and other affiliates that conduct Medicare, or other federal health program business are routinely subject to reviews, regulatory inquiries, audits, and examinations by various state insurance and health regulatory authorities and other state and federal authorities, including State Attorneys General. Aetna Better Health of West Virginia's understanding of the request for information pertaining to "investigations" is that it does not include such reviews, audits, examinations, or regulatory inquiries and is limited to matters that have been deemed "investigations." If our understanding is incorrect, we will produce additional information upon request.

HHS-OCR found that there was not enough evidence to show that Aetna violated any law and closed the investigation.

- On March 23, 2018, the HHS-OCR opened an investigation after receiving a complaint alleging that Mercy Maricopa Integrated Care engaged in unlawful withholding of medical records covered under Health Insurance Portability and Accountability Act. On June 05, 2018 HHS-OCR closed the case without further action.
- In October 2019, Aetna Better Health of Pennsylvania received a Civil Investigative Demand (CID) from the United States Attorney's Office for the Western District of Pennsylvania. The scope of the government's CID is presently unknown, but it appears to inquire into the adequacy of Aetna's network of Medicaid pediatric providers. Aetna is fully cooperating with this CID.

Aetna Better Health of West Virginia's parent companies, including other managed care subsidiaries of the parent companies that conduct Medicare or other federal health program business, have been subject to the following investigations within the last two years:

- The United States Attorney's Office for the Eastern District of Kentucky investigated a complaint it received against Coventry Healthcare of Missouri, Inc. (Coventry), alleging a violation of Title III of the American with Disabilities Act of 1990, as amended, 42 USC 12181-12189, and its implementing regulation. Effective January 30, 2019, Coventry entered into an informal resolution on the matter, which was not an admission of liability.
- In April 2016, Aetna Health Inc. received a subpoena from the New Jersey Attorney General's Office regarding an investigation into the award of the state's group Medicare contract. Aetna is cooperating with the investigation, which is currently pending.
- In May 2017, CVS Health received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare by SilverScript Insurance Company in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

CVS Health acquired Aetna Inc. on November 28, 2018. **Appendix C** includes the sections of Aetna Inc.'s 10-K or 10-Q filings that describe certain legal proceedings, including investigations, affecting Aetna Inc. for the portion of the applicable 2-year lookback period before CVS Health acquired Aetna Inc., which includes Aetna Inc.'s 2017 10-Ks and 10-Qs for the first three quarters of 2018. **Appendix C** also includes the section of CVS Health's 10-Ks

and 10-Qs, which describe certain legal proceedings, including investigations, affecting CVS Health for the applicable 2-year lookback period, which includes 10-Ks for the 2017 and 2018 calendar years and 10-Qs for the first three quarters of 2019. CVS Health's 2019 10-K is scheduled to be released on February 18, 2020, which is the same day as the response to the Request for Proposal is due. Due to production, printing, and delivery schedules, we were unable to include a copy of CVS Health's 2019 10-K in **Appendix C**. If the Department would like to review CVS Health's 2019 10-K we will provide it upon request, or the Department may directly access the document at https://investors.cvshealth.com/investors/sec-filings/default.aspx.

Appendix C also includes regulatory actions, sanctions, citations, deficiencies, audit findings, contingencies[2], or recommendations received in any state within the last two years, along with the response and plan of correction, for Aetna Better Health of West Virginia, its parent companies, and any other managed care subsidiaries[3] of the parent companies, as they existed at the time this Request for Proposal was issued, that conduct Medicaid, Medicare or any other federal health care program business.

On January 23, 2020, our ultimate parent, CVS Health, acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare), which is now a subsidiary of CVS Health and an affiliate of Aetna Better Health of West Virginia. Regulatory actions, sanctions, citations, deficiencies, audit findings, investigations, contingencies, or recommendations received by IlliniCare in the last two years in

[2] Aetna Better Health of West Virginia understands the term 'contingencies' to mean threatened regulatory actions, sanctions, citations, deficiencies or open audits. If our understanding is incorrect, we will produce additional information upon request.
[3] The table in Appendix C titled "Sanctions for Vendor and Medicaid Health Plans Managed by Aetna" also includes known regulatory actions, sanctions, citations, deficiencies, audit findings, contingencies, or recommendations received in any state within the past two years by Medicaid health plans that are managed by Aetna's national Medicaid organization, but which are not subsidiaries of our ultimate parent company, CVS Health.

connection with its Medicaid, Medicare or other federal health program business are included in **Appendix C** in the table titled Sanctions for IlliniCare Health Plan, Inc.

Disclose if the Vendor or its parent company (including other managed care subsidiaries of the parent) has had a Medicaid, Medicare, or any other federal health program managed care contract terminated or not renewed for any reason within the past five (5) years, or if it has elected to terminate or non-renew. In instances of involuntary termination or non-renewal, the Vendor should describe the issues and the parties involved, and provide the address and telephone number of the principal terminating party. The Vendor should also describe any corrective action taken to prevent any future occurrence of the problem(s) that may have led to the termination or non-renewal. In instances of voluntary termination or non-renewal, the Vendor should describe the factors contributing to its decision.

Contract Terminations and Non-Renewals

Aetna Better Health of West Virginia is proud that we have no contract terminations or non-renewals to report pertaining to our health plan.[4]

In the past five years, managed care subsidiaries of Aetna Better Health of West Virginia's ultimate parent company have not had a Medicaid, Medicare, or any other federal health program managed care contract terminated or not renewed for cause. **Table 3.4.1-1** and **Table 3.4.1-2** disclose instances where, in the past five years, managed care subsidiaries of Aetna Better Health of West Virginia's ultimate parent company have had a Medicaid, Medicare, or any other federal health program managed care contract terminated before the contract end date or not renewed for reasons unrelated to poor or non-performance, or where such managed care subsidiaries have elected to terminate or non-renew a Medicaid managed care contract.

[4] In 2016, the State of West Virginia re-procured its managed Medicaid contracts, and, pursuant to that procurement process, entered into a new contract with Aetna for state fiscal year 2017 (i.e., July 1, 2016 through June 30, 2017), even though the prior fiscal year's contract still had unused renewal options. There was no gap in Aetna's coverage/service as a Medicaid managed care organization (MCO) in West Virginia. We do not understand this to constitute a non-renewal that would fall within the scope of this question.

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Table 3.4.1-1: Contract Terminations and Non-Renewals for Medicaid Managed Care Subsidiaries of Aetna Better Health of West Virginia's Ultimate Parent[5]

Entity Name	Client Name	Date of Action	Name, Address, and Telephone Number of Terminating Party, If Applicable	Reason(s) for Termination or Non-Renewal	Corrective Action Taken, If Applicable
Aetna Better Health Inc. dba Aetna Better Health of Illinois	Illinois Department of Healthcare and Family Services	12/2017	Illinois Department of Healthcare and Family Services Bureau of Managed Care, Division of Medical Programs 100 So. Grand Ave. East Springfield, IL 62762 217-524-7478	After the 2017 re-procurement of the State of Illinois' Medicaid program, the Illinois Department of Healthcare and Family Services partially terminated (other than runout) this contract known as the Family Health Plan/Affordable Care Act contract, with all incumbent MCOs before the scheduled end date to accommodate the start date of the newly awarded contracts to successful bidders. The contract was in runout through 12/31/19.	N/A

[5] We understand the term "managed care subsidiaries" to be limited to subsidiaries of our ultimate parent that hold Medicaid, Medicare, or other federal health program managed care contracts directly with state or federal agencies rather than companies that provide services to managed care plans that, in turn, hold such contracts. Similarly, we understand the term "managed care contract" to be limited to Medicaid, Medicare, or other federal health program contracts that managed care subsidiaries hold directly with a state or federal agency to provide managed care services to enrollees. Accordingly, we have not included terminations of contracts held by subsidiaries of our ultimate parent to provide services (e.g., pharmacy benefits services, plan management services) to other entities that, in turn, hold Medicaid, Medicare, or other federal health program managed care contracts with a state or federal agency. If our understanding is incorrect, we will produce additional information upon request.

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Entity Name	Client Name	Date of Action	Name, Address, and Telephone Number of Terminating Party, If Applicable	Reason(s) for Termination or Non-Renewal	Corrective Action Taken, If Applicable
Aetna Better Health Inc. dba Aetna Better Health of Illinois	Illinois Department of Healthcare and Family Services	12/2017	Illinois Department of Healthcare and Family Services Bureau of Managed Care, Division of Medical Programs 100 So. Grand Ave. East Springfield, IL 62762 217-524-7478	After the 2017 re-procurement of the State of Illinois' Medicaid program, the Illinois Department of Healthcare and Family Services partially terminated (other than runout) this contract, known as the Integrated Care Program contract, with all incumbent MCOs before the scheduled end date to accommodate the start date of the newly awarded contracts to successful bidders. The contract was in runout through 12/31/19.	N/A
Aetna Better Health Inc. dba Aetna Better Health of Illinois	Illinois Department of Healthcare and Family Services	12/2017	Illinois Department of Healthcare and Family Services Bureau of Managed Care, Division of Medical Programs 100 So. Grand Ave. East Springfield, IL 62762 217-524-7478	After the 2017 re-procurement of the State of Illinois' Medicaid program, the Illinois Department of Healthcare and Family Services partially terminated (other than runout) this contract known as the Managed Long Term Supports and Services contract, with all incumbent MCOs before the scheduled end date to accommodate the start date of the newly awarded contracts to successful bidders. The contract was in runout through 12/31/19.	N/A

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Entity Name	Client Name	Date of Action	Name, Address, and Telephone Number of Terminating Party, If Applicable	Reason(s) for Termination or Non-Renewal	Corrective Action Taken, If Applicable
Aetna Health of Iowa Inc. dba Coventry Health Care of Iowa, Inc.	Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)	12/2015	Iowa Department of Human Services Iowa Medicaid Enterprise 100 Army Post Rd. Des Moines, IA 50315 515-256-4621	Coventry Health Care of Iowa, Inc. had a memorandum of understanding (MOU) with the Iowa Department of Human Services, Iowa Medicaid Enterprise (IME) for participation in the Iowa Marketplace Choice Plan. The MOU did not have an end date. The IME terminated the MOU effective January 1, 2016 because the population rolled into the State's new managed care program.	N/A
Aetna Better Health of Missouri LLC	Missouri HealthNet Division	04/2017	Missouri HealthNet Division P.O. Box 1527 Jefferson City, MO 65102 573-526-4274	The contract, as amended, had an additional one-year renewal period that the State could have exercised but did not because, instead, it rebid its Medicaid program and entered into new contracts with successful bidders.	N/A

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Entity Name	Client Name	Date of Action	Name, Address, and Telephone Number of Terminating Party, If Applicable	Reason(s) for Termination or Non-Renewal	Corrective Action Taken, If Applicable
Aetna Better Health of Nevada Inc. dba Aetna Better Health of Nevada	Nevada Department of Health and Human Services Division of Health Care Financing and Policy	08/2017	Aetna Better Health of Nevada (This health plan is no longer operational. If information is needed, the Department may contact Aetna's Medicaid business unit at): Aetna Medicaid Administrators LLC 4500 E. Cotton Center Blvd., Bldg. 1 Phoenix, AZ 85040 602-659-1643	Due to the extremely low redistribution of less than 2,000 enrollees, far less than the critical number of enrollees needed to ensure a viable Medicaid plan capable of delivering quality care and competitive programs, Aetna Better Health of Nevada Inc. gave notice to terminate the contract in accordance with the contract terms. To minimize enrollee disruption that would result from continuing to enroll new enrollees and then transitioning them to new health plans after the notice period ended, the State opted to waive the full, contractually required 180-day notice period. Aetna agreed to the State's timeline and assisted the State in transitioning enrollees to new health plans.	N/A

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Entity Name	Client Name	Date of Action	Name, Address, and Telephone Number of Terminating Party, If Applicable	Reason(s) for Termination or Non-Renewal	Corrective Action Taken, If Applicable
Aetna Better Health Inc. dba Aetna Better Health of New York	Centers for Medicare & Medicaid Services and New York Department of Health	12/2017	Aetna Better Health of New York 55 W. 125th St. New York, NY 10027 401-770-5250	New York's Fully Integrated Duals Advantage program faced enrollment challenges since its inception because it is not mandatory and most eligible people who were initially enrolled automatically in the program chose to opt out. Because our enrollment never exceeded 70 enrollees, the plan made the business decision to exit the program. In accordance with the notice requirements of the contract, we gave notice of our intent to terminate the contract in June 2017 but continued to serve enrollees under the contract until December 31, 2017.	N/A

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Table 3.4.1-2: Contract Terminations and Non-Renewals for Medicare Managed Care Subsidiaries of Aetna Better Health of West Virginia's Ultimate Parent[6]

Entity Name	Client Name	Date of Action	Name, Address, and Telephone Number of Terminating Party	Reason(s) for Termination or Non-Renewal	Corrective Action Taken, If Applicable
Aetna Health, Inc.	Centers for Medicare & Medicaid Services	12/2015	Aetna Health, Inc 3900 Rogers Rd, San Antonio, TX 78251 Michael Kavouras Vice President, Medicare Advantage 630-737-7850	Aetna Health, Inc. voluntarily withdrew this contract based on a business decision to streamline and simplify plan offerings in the market and reduce administrative burden and costs associated with maintaining multiple contracts.	N/A
Aetna Health, Inc.	Centers for Medicare & Medicaid Services	12/2014	Aetna Health, Inc. 980 Jolly Road Blue Bell, PA 19422 Michael Kavouras Vice President, Medicare Advantage 630-737-7850	Aetna Health, Inc. voluntarily withdrew this contract based on a business decision to streamline and simplify plan offerings in the market and reduce administrative burden and costs associated with maintaining multiple contracts.	N/A

[6] We understand the term "managed care subsidiaries" to be limited to subsidiaries of our ultimate parent that hold Medicaid, Medicare, or other federal health program managed care contracts directly with state or federal agencies rather than companies that provide services to managed care plans that, in turn, hold such contracts. Similarly, we understand the term "managed care contract" to be limited to Medicaid, Medicare, or other federal health program contracts that managed care subsidiaries hold directly with a state or federal agency to provide managed care services to enrollees. Accordingly, we have not included terminations of contracts held by subsidiaries of our ultimate parent to provide services (e.g., pharmacy benefits services, plan management services) to other entities that, in turn, hold Medicaid, Medicare, or other federal health program managed care contracts with a state or federal agency. If our understanding is incorrect, we will produce additional information upon request.

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Entity Name	Client Name	Date of Action	Name, Address, and Telephone Number of Terminating Party	Reason(s) for Termination or Non-Renewal	Corrective Action Taken, If Applicable
Coventry Health Care of Florida, Inc.	Centers for Medicare & Medicaid Services	12/2014	Coventry Health Care of Florida, Inc. 1340 Concord Terrace Sunrise, FL 33323 Michael Kavouras Vice President, Medicare Advantage 630-737-7850	Coventry Health Care of Florida, Inc. voluntarily withdrew this contract based on a business decision to streamline and simplify plan offerings in the market and reduce administrative burden and costs associated with maintaining multiple contracts.	N/A
Coventry Health Care of Illinois, Inc.	Centers for Medicare & Medicaid Services	12/2014	Coventry Health Care of Illinois, Inc. 2110 Fox Drive, Suite A Champaign, IL 61820 Michael Kavouras Vice President, Medicare Advantage 630-737-7850	Coventry Health Care of Illinois, Inc. voluntarily withdrew this contract based on a business decision to streamline and simplify plan offerings in the market and reduce administrative burden and costs associated with maintaining multiple contracts.	N/A

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Entity Name	Client Name	Date of Action	Name, Address, and Telephone Number of Terminating Party	Reason(s) for Termination or Non-Renewal	Corrective Action Taken, If Applicable
First Health Life & Health Insurance Company	Centers for Medicare & Medicaid Services	12/2015	First Health Life & Health Insurance Company 6705 Rockledge Drive, Suite 900 Bethesda, MD 20817 Michael Kavouras Vice President, Medicare Advantage 630-737-7850	First Health Life & Health Insurance Company voluntarily withdrew this contract based on a business decision to streamline and simplify plan offerings in the market and reduce administrative burden and costs associated with maintaining multiple contracts.	N/A

5. References

The State may conduct reference checks to verify and validate the past performance of the Vendor and its proposed subcontractors.

5.1 Vendor (Prime) References Form

Include at least three (3) references from clients served within the last three (3) years that demonstrate the Vendor's ability to perform the scope of work described in this RFP. The Vendor should provide three (3) different clients in order to demonstrate its experience.

The Vendor should include client description, contract dates, and contact information (customer points of contact, addresses, telephone numbers, and email addresses). The Vendor should explain whether it performed the work as a prime contractor or as a subcontractor. The Vendor should provide their response as part of their bid in accordance with the template below. The Vendor may add additional Reference Tables as necessary.

Table 8: Vendor References #1

Vendor Information		
Vendor Name: Aetna Better Health Inc. dba Aetna Better Health of New Jersey (Aetna Better Health of New Jersey)	Contact Name:	Glenn MacFarlane
	Contact Phone:	609-282-8201
Customer Information		
Customer Organization: New Jersey Department of Human Services, Division of Medical Assistance and Health Services	Contact Name:	Jennifer Langer Jacobs
	Contact Title:	Assistant Commissioner, Division of Medical Assistance & Health Services
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-588-2600
	Contact Email:	Jennifer.Jacobs@dhs.state.nj.us
Project Information		
Total Vendor Staff:	188	
Project Objectives: The New Jersey Medicaid FamilyCare program supports health promotion, disease prevention, specialty care for those who require such care, diagnostic and intervention strategies, home therapies, and ongoing ancillary services, as well as the long-term management of ongoing medical complications, and continuation of existing relationships with out-of-network providers when considered to be in the best interest of enrollees with special health care needs. Aetna Better Health of New Jersey's integrated approach employs best practices for integrating the delivery of care for enrollees, including Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), Aged, Blind or Disabled (ABD), and long-term services and supports (LTSS) recipients, throughout the entire continuum		

of care, including acute care, behavioral health treatment, institutional and facility services, and home- and community-based services (HCBS).

Project Description:

The New Jersey Medicaid FamilyCare program provides health coverage to children, pregnant women, parents/caretaker relatives, single adults, childless couples, the aged, blind, disabled, and individuals qualified for long-term care services. New Jersey FamilyCare's comprehensive health coverage provides a wide range of services including doctor visits, hospital services, prescriptions, tests, vision care, mental health care, dental, nursing home care and other health care services, depending on the person's eligibility category.

Vendor's Involvement:

Aetna Better Health of New Jersey offers Medicaid, CHIP and Managed Long-Term Services and Supports (MLTSS) to New Jersey FamilyCare members in all 21 counties. Aetna Better Health of New Jersey administers care management. Aetna Better Health of New Jersey collaborates with the relevant State agencies and community resources in accordance with contract requirements and Aetna's Members with Special Health Care Needs policies. Every year, the plan invites staff from State agencies to participate in joint meetings to discuss current issues and update processes and contractual requirements. Members receiving care management, and their families, are invited to attend quarterly Member Advisory Meetings, which are held on a rotating basis in different areas of the state, where they can receive in-person consultations with Aetna staff.

Aetna Better Health of New Jersey Integrated Care Management (ICM) and Utilization Management (UM) teams collaborate both informally and through joint attendance at rounds and case conferences to assure that the needs of our members are met, with special attention to those with special needs. One or more ICM representatives attend daily UM rounds to help ensure effective communication. When special issues arise, representatives from ICM and UM attend a case conference with the medical director to discuss opportunities and develop solutions.

In addition, the medical director reviews and discusses all cases in which individuals require private duty nursing to help ensure members' needs are met and to address under- or over-utilization of services appropriately; this occurs regardless of whether the member is in Core Medicaid (with an Early and Periodic Screening, Diagnostic and Treatment [EPSDT] benefit) or the MLTSS program.

The special needs dental director addresses all issues related to dental care, including communication with the dental vendor and review of special cases. Aetna Better Health of New Jersey also covers the benefit for Pediatric Medical Day Care, intended for young children who are medically complex or technology dependent. This benefit allows children to remain at home while receiving supportive care daily.

Project Benefits:

Aetna Better Health of New Jersey supports a collaborative model among departments, including Utilization Management, Care Management, and Behavioral Health, to optimize communication to address members' needs within the structure of the benefit. Aetna Better Health of New Jersey excels at care management, which is individualized and addresses the whole member in a model that integrates physical health, behavioral health, and the social determinants of health (SDOH). This dedication has contributed to Aetna Better Health of New Jersey achieving low rates of hospital readmission, averaging between 5 and 8 percent. The plan's MLTSS Care Management team achieved a $1 million State incentive for MLTSS quality. Aetna Better Health of New Jersey exceeded the State benchmark for home visits (10 percent of members in care management) by achieving 16 percent. Aetna Better Health of New Jersey received a 91

percent from IPRO and the Division of Medical Assistance and Health Services on the annual Medicaid audit in 2018. During the National Committee for Quality Assurance (NCQA) onsite review Aetna Better Health of New Jersey received a score of 49 out 50 possible points, attaining full NCQA accreditation.

Key Personnel	
Name: Glenn MacFarlane	Role: Chief Executive Officer
Name: Christina Taggart	Role: Interim Chief Operating Officer
Name: Pat Brosnan	Role: Interim Chief Financial Officer
Name: Cheryl Reid, MD	Role: Chief Medical Officer
Name: Pam Persichilli	Role: Director, Clinical Services
Name: Terri Cortina	Role: Director, Pharmacy
Name: Ashley Bolduc	Role: Head, Primary Care Services and Marketing
Name: Mark Horzepa	Role: Compliance Officer
Name: Kate Andujar	Role: Director, Managed Long Term Services
Name: Sally O'Brien	Role: Director, Behavioral Health

Project Measurements:	
Projected Membership of Vendor's Contract: 85,000	Actual Membership of Vendor's Contract: 65,643
Reason(s) for Change in Membership: Statewide membership decrease, partly due to change in State requirements for applicant documentation and partly due to improved state economy.	

Estimated Start and Completion Dates:	From:	Current Contract: 12/1/2014	To:	N/A; evergreen contract
Actual Start and Completion Dates:	From:	Current Contract: 12/1/2014	To:	N/A; evergreen contract

Reason(s) for Difference Between Estimated and Actual Dates: Not Applicable

If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: Not Applicable

Table 8: Vendor References #2

Vendor Information		
Vendor Name: Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia (Aetna Better Health of Virginia)	Contact Name:	Jerry Mammano
	Contact Phone:	609-282-7957
Customer Information		
Customer Organization: Virginia Department of Medical Assistance Services	Contact Name:	Daniel Plain
	Contact Title:	Director, Health Care Services Division
Customer Address: 600 East Broad Street, 11th Floor, Richmond, Virginia 23219	Contact Phone:	804-588-4883
	Contact Email:	Daniel.Plain@dmas.virginia.gov
Project Information		
Total Vendor Staff:	508	

Project Objectives:

The focus of Medallion 4.0 is to evolve from the Medallion 3.0 foundation, engage health systems and stakeholders, provide holistic and integrated care, add new services and populations, provide flexible delivery systems and payment models, and to grow stronger through improved quality, data, and reporting.

The Department of Medical Assistance Services (DMAS), hereinafter referred to as the Department or DMAS, is the single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Children's Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act. Medallion 4.0 is the next iteration of DMAS' longstanding Medallion II and Medallion 3.0 Medicaid and FAMIS Managed Care Programs and is focused on improving quality, access, and efficiency.

Medallion II was Virginia's first mandatory managed care program. As the program expanded wide (statewide) and deep (additional populations), Medallion II was rebranded Medallion 3.0 with a renewed focus on the areas of systems integration, contract and quality monitoring, compliance, and program integrity. Virginia seeks to strengthen and reinvigorate this model by adjusting the included populations and services.

Project Description:

Virginia Medicaid provides access to medical services, including outpatient care (primary or specialty care services), hospital care, nursing facility services, and behavioral health services. Medicaid/FAMIS covers vital health care services including preventive screening, treatment, or care for acute illness, and dental services. Medicaid/FAMIS focuses on giving Virginia's children a healthy start in life by keeping pregnant women healthy. Services for pregnant women include prenatal care, other comprehensive health care services, and dental health.

The scope of Medallion 4.0 includes medical, behavioral health, pharmacy, vision, and non-emergency medical transportation. Populations include pregnant women, infants, children, low-income adults, children/youth with special health care needs, children in foster care and individuals formerly in foster care, and individuals receiving Supplemental Security Income. The Medallion 4.0 program builds on the

strengths and experience of the 20-year Medallion program and will closely align with the new Commonwealth Coordinated Care Plus (CCC Plus) program. Together and where feasible, Medallion 4.0 and CCC Plus, both of which Aetna Better Health of Virginia actively participate in streamlined policies and processes related to a value-based purchasing, common core formulary, data integrity, quality, etc.

The Medallion 4.0 program:

- Continues to serve children, pregnant women, and parents
- Covers and coordinates services, such as early intervention and non-traditional behavioral health services, which were previously "carved out" and paid through traditional fee-for-service Medicaid
- Supports alternate payment methods in Virginia.

The goals and expectations of the Medallion 4.0 Program include the following:

- Improving quality of life and health outcomes for enrolled individuals
- Providing a seamless, one-stop system of services
- Facilitating communication between providers to improve the quality and cost-effectiveness of care
- Providing systemwide monitoring and quality improvement
- Ensuring the use of culturally, linguistically, and ability-appropriate consumer and family educational materials
- Increasing appropriate use of screening and prevention services

Vendor's Involvement:

Aetna Better Health of Virginia contracts with DMAS to provide managed care services to members in the Medicaid (Medallion), CHIP(FAMIS), Long Term Supports and Services (Commonwealth Coordinated Care Plus, and Dual Eligible Special Needs Plans (D-SNP) populations.

Aetna Better Health of Virginia is licensed as a health management organization and as a Managed Care Health Insurance Plan in the State of Virginia. Aetna Better Health of Virginia is also a NCQA-accredited Medicaid health plan. Aetna Better Health of Virginia has more than 20 years of experience in serving Virginia Medicaid recipients. This longstanding relationship has allowed us to understand, build, and foster relationships with our communities to facilitate fully integrated systems of care and offer a consumer-centric delivery system of care for our members.

Aetna Better Health of Virginia continues to invest time and support in our members, to change behaviors, follow their physician's treatment recommendations, and adopt healthier lifestyles. Aetna Better Health of Virginia understands that each member is unique, which is why we collaborate to deliver individualized, person-centered care to each of our members. We do this by caring for, empathizing with, listening to, planning for, and educating enrollees to reach a common understanding of trust and shared goals to reduce health disparities and promote health population.

Aetna Better Health of Virginia has developed and managed a robust provider network in the Commonwealth, capable of meeting the health care needs of our members in an accessible, timely, and convenient manner in all six regions. Our provider network is the foundation to our fully integrated systems and is designed to support members in providing a seamless system of services.

Project Benefits:

The scope of Medallion 4.0 includes medical, behavioral health, pharmacy, vision, and non-emergency medical transportation.

Fully Integrated System of Care and Integrated Care Management

Our members are best served by a holistic approach that incorporates a coordinated network of physical and behavioral health care providers, as well as community-based organizations. Our integrated care management program and care coordination system—the cornerstone of our approach for the Medallion 4.0 program—facilitates collaboration among members, practitioners, providers, care coordinators, family members, the member's circle of support, community organizations, and existing case management entities, thus resulting in a seamless system of services.

Aetna Better Health of Virginia works to understand each member's readiness to change, individual preferences and goals, and physical and behavioral health care needs. We assess family and community supports, strengths, and any barriers affecting the member's access to care. In doing so, we help each member achieve their goals and optimize their level of self-care and independence. Our fully integrated system of care is specifically designed to manage members with complex needs. Aetna Better Health of Virginia uses analytic methods to identify our most bio-psychosocially complex and vulnerable members for whom we have an opportunity to make a significant difference.

Aetna Better Health of Virginia is addressing social determinants of health (SDOH) in a meaningful way and providing locally tailored solutions that integrate community initiatives with the health care delivery system. We assess SDOH by capturing data through multiple mechanisms including health risk assessments, condition-specific assessments, existing care plans, gaps-in-care reports, reports through our health care equity dashboard, predictive modeling, care coordination claims data, provider feedback, community health workers, community and advocate outreach, member surveys, member advocacy committees, and focus groups. Our health care equity dashboard tracks utilization and identifies members who may benefit from additional interventions and education. It also provides inpatient and emergency department usage by gender, age, race, ethnicity, and county.

Similarly, providers access real-time admission, discharge, and transfer information for emergency department, inpatient, and outpatient utilization at the individual member level in collaboration with the Commonwealths Emergency Departments Information Exchange program, Pre-Merge.

Behavioral Health

Aetna Better Health of Virginia provides both traditional and non-traditional behavioral health services including intensive in-home services, day treatment/partial hospitalization, residential, psychosocial rehabilitation, crisis services (including trauma-informed care and adverse childhood events), intensive community treatment, and mental health skill building for adults.

School-based Services

Aetna Better Health of Virginia supports members through school-based services, and we have expanded these services across the Commonwealth. We employ a multidisciplinary team to provide the services through a youth-centered approach that is sensitive, non-judgmental, responsive, comprehensive, accessible, and culturally competent. Aetna Better Health of Virginia established an advisory board comprised of students, family, teachers, staff, and community representatives to provide assistance in the implementation and ongoing operational monitoring of the program and to gain feedback and build upon effective experiences, as well as challenges. As we have in multiple states, we collaborated with the schools to build memoranda of understanding and mixed services protocols to ensure every child and family receives the services they need.

Dental Services

Our community-based outreach team meets with oral health stakeholders within Virginia and has demonstrated that existing oral health inequities affect both adults and children. By providing additional

preventive and therapeutic services, Aetna Better Health of Virginia leads the charge for better health outcomes in Virginia—fulfilling our mission to improve our members' overall health by integrating oral health care into total wellness. We currently administer a suite of dental services, including diagnostic, preventive, restorative/surgical procedures, and orthodontia services. We also collaborate with primary care providers, pediatricians, federally qualified health centers, hospitals, and other stakeholders to educate our members—particularly pregnant women, children, and those with comorbidities and special needs—about the importance and impact of preventive care on overall wellness.

Plan First Family Planning

Aetna Better Health of Virginia promotes family planning services for men and women, including yearly exams, pap tests, sexually transmitted infection (STI) testing, lab services, family planning education, counseling, sterilization procedures, prescription contraceptives, over-the-counter contraceptives, and securing transportation for members to attend appointments. Aetna Better Health of Virginia leverages our network across the Commonwealth and provides 180 days of care transitions to make sure members receive uninterrupted services if their providers are not yet contracted with us. We assume the responsibility for the management of all services available to Plan First members, which include the addition of treatment for any STIs identified during testing. Aetna Better Health of Virginia leverages the strengths of the current program and facilitates adjustments (as needed) to enhance access and engagement of members. Additionally, we work with schools and community organizations to share knowledge, provide services, and offer classes to youth and new families. In doing so, Aetna Better Health of Virginia manages a successful program, thus decreasing unintended pregnancies and infant mortality rates, while increasing positive birth outcomes.

Key Personnel	
Name: Jerry Mammano	Role: Chief Executive Officer
Name: Ira Bloomfield, MD	Role: Medical Director
Name: Neil Hines, MD	Role: Behavioral Health Lead
Name: Lani Spencer, RN	Role: Care Coordination Manager
Name: Kimberly Grifasi	Role: Quality Improvement Program Manager

Project Measurements:	
Projected Membership of Vendor's Contract: N/A–No projected Membership was identified	Actual Membership of Vendor's Contract: 171,000
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of 6 12-month renewals

Actual Start and Completion Dates:	From:	Contract Start: 8/1/18 Tenure in State: Since 1996	To:	June 30, 2020, with the possibility of 6 12-month renewals
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: N/A				

Table 8: Vendor References #3

Vendor Information		
Vendor Name: Aetna Better Health of Florida, Inc. (fka Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida)	Contact Name:	Claudia Lamazares
	Contact Phone:	954-858-3208
Customer Information		
Customer Organization: Florida Agency for Health Care Administration	Contact Name:	Beth Kidder
	Contact Title:	Deputy Secretary of Medicaid
Customer Address: 2727 Mahan Drive, Mail Stop #8, Tallahassee, FL 32308	Contact Phone:	850-412-4000
	Contact Email:	Beth.Kidder@ahca.myflorida.com
Project Information		
Total Vendor Staff:	351	
Project Objectives: The Agency's overall objective is for Medicaid enrollees to receive all medically necessary services in a timely manner and in the most appropriate setting, thereby achieving the best possible quality outcomes while containing costs. The Agency awarded contracts to nationally accredited managed care plans that offer comprehensive, quality-driven provider networks, streamlined processes that enhance the enrollee and provider experience, expanded benefits targeted to improve outcomes for enrollees, top quality scores, and high rates of enrollee satisfaction to deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model. In addition to the objectives stated above, the Agency awarded contracts to managed care plans that offer innovative and evidence-based approaches in meeting the following goals under the Medicaid program: • Reduce potentially preventable inpatient and outpatient hospital events, and unnecessary ancillary services • Improve birth outcomes		

- Rebalance long-term services and supports systems by increasing the percentage of enrollees receiving services in the community instead of an institution

Project Description:

The State of Florida has offered Medicaid services since 1970. Medicaid is funded by both the State and federal government to provide health care coverage for eligible children, seniors, adults with disabilities, parents of children and pregnant women. The annual budget for the program is more than $25 billion and makes up the largest part of the total Florida budget. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, Florida Statutes) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: Managed Medical Assistance (MMA) and Long-term Care (LTC). More than 3.2 million Floridians are enrolled in Florida's SMMC program.

Vendor's Involvement:

Aetna Better Health of Florida serves the CHIP, TANF, ABD, LTSS, and dually eligible populations under the SMMC/ Florida State Medicaid contract. We hold a comprehensive MMA and LTC contract in Regions, 6, 7 and 11; representing the three largest metropolitan areas of the State: Tampa, Orlando, and Miami-Dade County.

In partnership with providers, community organizations and resources, and other key stakeholders, we offer an extensive suite of programs and services that work in concert to meet the individual needs of our enrollees. Our integrated, person-centered approach drives our decision-making, informs our policies and culture, and fosters our ongoing efforts with physicians, hospitals, and health networks to align economic incentives.

We work closely and collaboratively with our provider networks to integrate our innovative solutions in ways that complement their existing technology and health care service delivery goals. Specific offerings include a progressive payment model, innovative data-sharing technology, care management and care coordination resources, and technical support that work in harmony to assure alignment across the care continuum. Aetna's progressive approach to driving high-quality, positive outcomes gives providers an array of payment arrangements for increasing clinical and financial complexity and sophistication in risk-sharing.

Provide all managed medical services including inpatient, outpatient and ancillary services. Our scope of services includes the following activities/services:

- Utilization Management: prior authorization, concurrent review, discharge planning, retrospective review
- Quality Management: HEDIS® and other benchmarks, evidence-based clinical guidelines, inter-rater reliability reviews, clinical studies, over and under-utilization reviews, drug utilization reviews, grievance and appeal trend reviews, surveys, quality of care complaint management
- Care Coordination: case management – telephonic and face to face, predictive modeling, risk stratification, transition of care, assessments (health risk assessments, assessments and reassessments of chronic and complex conditions, EPSDT, perinatal-maternal/child health assessments), screening for behavioral health and substance abuse, care plan development, multidisciplinary rounds, transportation coordination, prevention and wellness initiatives, referrals, medication maintenance
- Disease Management: chronic conditions
- Member Services: primary care provider (PCP) assignments/selection, inquiries/hotline, outreach, complaints, education, handbook, website
- Provider Services: contracting, inquiries/hotline, provider manual, education, outreach, website

- Compliance and cultural competency program
- Manage and coordinate services for members residing in skilled nursing facilities, assisted living facilities and home and community-based settings with acute care and behavioral health services, including case management
- Operations/claims processing and payment
- State and regulatory reporting

Project Benefits:

The SMMC program covers a range of services including outpatient, hospital, behavioral health, substance abuse, community case management, targeted care management, transportation, pharmacy, Nursing Home and Assisted Living Facility Services, medical foster care, vision, and family planning.

Aetna Better Health of Florida works closely and collaboratively with our provider networks to integrate our innovative solutions in ways that complement their existing technology and health care service delivery goals. Specific offerings include a progressive payment model, innovative data-sharing technology, care management and care coordination resources, and technical support that work in concert to align across the care continuum. Aetna's progressive approach to driving high-quality, positive outcomes gives providers an array of payment arrangements for increasing clinical and financial complexity and sophistication in risk-sharing.

This integrated approach has helped us to improve care and achieve high levels of provider satisfaction, including decreasing readmissions by 18% in 2018-2019, decreasing emergency room use by 14%, and achieving 86% provider satisfaction scores in 2019.

Key Personnel	
Name: Jennifer Sweet	Role: Chief Executive Officer
Name: Claudia Lamazares	Role: Chief Operating Officer
Name: George Yokley	Role: Chief Financial Officer
Name: David Gilchrist D.O.	Role: Chief Medical Officer
Name: Denise Kissane R.N	Role: Vice President of Health Services
Name: Trennette Gilbert	Role: Director of Account Management

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 95,768
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	10/1/2018	To:	9/30/2023
Actual Start and Completion Dates:	From:	10/1/2018	To:	9/30/2023

Reason(s) for Difference Between Estimated and Actual Dates:
N/A

If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: N/A

5.2 Subcontractor References

If the Vendor's proposal includes the use of subcontractor(s), provide three (3) references for each subcontractor. The Vendor should provide their response as part of their bid in accordance with the template below. The Vendor may add additional Reference Tables as necessary. **The State prefers references that demonstrate where the Prime and subcontractors have worked together in the past.**

Active Health Management, Inc.

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: Active Health Management, Inc. (ActiveHealth)	Contact Name:	Jacquelyn Dunphy
	Contact Phone:	917-774-2622
Customer Information		
Customer Organization: New Jersey Department of Human Services, Division of Medical Assistance and Health Services	Contact Name:	Jennifer Langer Jacobs
	Contact Title:	Assistant Commissioner, Division of Medical Assistance & Health Services
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-588-2600
	Contact Email:	Jennifer.Jacobs@dhs.state.nj.us
Project Information		
Total Vendor Staff:	ActiveHealth has approximately 820 staff members, which are employed by Aetna Resources LLC (Aetna Resources), an Employee Management Company and Aetna affiliate that provides labor services.	
Project Objectives: The New Jersey Medicaid FamilyCare program supports well-child care, health promotion, disease prevention, specialty care for those who require such care, diagnostic and intervention strategies, home therapies, and ongoing ancillary services, as well as the long-term management of ongoing medical complications, and continuation of existing relationships with out of network providers when considered to be in the best interest of enrollees with special health care needs. Aetna Better Health of New Jersey's integrated approach employs best practices for integrating the delivery of care for enrollees, including TANF, CHIP, ABD, and LTSS recipients, throughout the entire continuum of care, including acute care, behavioral health treatment, institutional and facility services, and HCBS.		
Project Description:		

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

The New Jersey Medicaid FamilyCare program provides health coverage to children, pregnant women, parents/caretaker relatives, single adults, childless couples, the aged, blind, disabled, and individuals qualified for long-term care services. New Jersey FamilyCare's comprehensive health coverage provides a wide range of services including doctor visits, hospital services, prescriptions, tests, vision care, mental health care, dental, nursing home care, and other health care services, depending on the person's eligibility category.
Vendor's Involvement: ActiveHealth provides a disease management program, tools, and services; services relating to NCQA accreditation. Active Health, an affiliate of Aetna Better Health of West Virginia, is a clinically based, technology-driven health management services company covering over 20 million enrollees. ActiveHealth has established capabilities, stability, and credibility with nearly 20 years of market leadership and innovation.
Project Benefits: ActiveHealth provides data process and program support for Aetna's disease management program to identify gaps in care and interventions.

Key Personnel	
Name: Mohamed Diab	Role: Chief Executive Officer
Name: Matthew J. Asmus	Role: Chief Financial Officer

Project Measurements:	
Projected Membership of Vendor's Contract: 85,000	Actual Membership of Vendor's Contract: 65,643
Reason(s) for Change in Membership: Statewide membership decrease, partly due to change in state requirements for applicant documentation and partly due to improved state economy	

Estimated Start and Completion Dates:	From:	Current Contract: 4/1/2017	To:	N/A; evergreen contract
Actual Start and Completion Dates:	From:	Current Contract: 4/1/2017	To:	N/A; evergreen contract

Reason(s) for Difference Between Estimated and Actual Dates: N/A
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: ActiveHealth provides a disease management program, tools, and services; services relating to NCQA accreditation.

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Active Health Management, Inc.	Contact Name:	Jacquelyn Dunphy
	Contact Phone:	917-774-2622
Customer Information		
Customer Organization: Virginia Department of Medical Assistance Services	Contact Name:	Daniel Plain
	Contact Title:	Director, Health Care Services Division
Customer Address: 600 East Broad Street, 11th Floor, Richmond, Virginia 23219	Contact Phone:	804-588-4883
	Contact Email:	Daniel.Plain@dmas.virginia.gov

Project Information	
Total Vendor Staff:	ActiveHealth has approximately 820 staff members, which are employed by Aetna Resources LLC (Aetna Resources), an Employee Management Company and Aetna affiliate that provides labor services.

Project Objectives: The focus of Medallion 4.0 was to evolve from the Medallion 3.0 foundation, engage health systems and stakeholders, provide holistic and integrated care, add new services and populations, provide flexible delivery systems and payment models, and to grow stronger through improved quality, data, and reporting.

The Department of Medical Assistance Services, hereinafter referred to as the Department or DMAS, is the single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Children's Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act. Medallion 4.0 is the next iteration of DMAS's long-standing Medallion II and Medallion 3.0 Medicaid and FAMIS Managed Care Programs and will focus on improving quality, access, and efficiency.

Medallion II was Virginia's first mandatory managed care program. As the program expanded wide (statewide) and deep (additional populations), Medallion II was rebranded Medallion 3.0 with a renewed focus on the areas of systems integration, contract and quality monitoring, compliance, and program integrity. Virginia seeks to strengthen and reinvigorate this model by adjusting the included populations and services.

Project Description:

The scope of Medallion 4.0 includes medical, behavioral health, pharmacy, vision, and non-emergency medical transportation. Populations include pregnant women, infants, children, low-income adults, children/youth with special health care needs, children in foster care and individuals formerly in foster care, and individuals receiving SSI.

Medicaid covers 1 in every 3 births in Virginia and almost 1 in 3 children. Virginia Medicaid provides access to medical services, such as: outpatient care (primary or specialty care services); hospital care, nursing facility services, and behavioral health services. Medicaid/FAMIS covers vital health care services like preventive screening, treatment, or care for acute illness, and dental services. Medicaid/FAMIS focuses on giving Virginia's children a healthy start in life by keeping pregnant women healthy. Services for pregnant women include prenatal care, other comprehensive health care services, and dental health.

Vendor's Involvement:

ActiveHealth provides a disease management program, tools, and services; services relating to NCQA accreditation. Active Health, an affiliate of Aetna Better Health of West Virginia, is a clinically based, technology-driven health management services company covering over 20 million enrollees. ActiveHealth has established capabilities, stability, and credibility with nearly 20 years of market leadership and innovation.

Project Benefits: ActiveHealth provides data process and program support for Aetna's disease management program to identify gaps in care and interventions.

Key Personnel	
Name: Mohamed Diab	Role: Chief Executive Officer
Name: Matthew J. Asmus	Role: Chief Financial Officer

Project Measurements:	
Projected Membership of Vendor's Contract: N/A–No projected Membership was identified	Actual Membership of Vendor's Contract: 171,000
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	Contract Start: 4/1/16	To:	N/A; evergreen contract
Actual Start and Completion Dates:	From:	Contract Start: 4/1/16	To:	N/A; evergreen contract

Reason(s) for Difference Between Estimated and Actual Dates:

N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

ActiveHealth provides a disease management program, tools, and services relating to NCQA accreditation.

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Active Health Management, Inc.	**Contact Name:**	**Jacquelyn Dunphy**
	Contact Phone:	917-774-2622
Customer Information		
Customer Organization: Florida Agency for Health Care Administration	Contact Name:	Beth Kidder
	Contact Title:	Deputy Secretary of Medicaid
Customer Address: 2727 Mahan Dr, Mail Stop #8, Tallahassee, Florida 32308	Contact Phone:	850-412-4000
	Contact Email:	Beth.Kidder@ahca.myflorida.com
Project Information		
Total Vendor Staff:	ActiveHealth has approximately 820 staff members, which are employed by Aetna Resources LLC (Aetna Resources), an Employee Management Company and Aetna affiliate that provides labor services.	

Project Objectives:

The Agency's overall objective is for Medicaid enrollees to receive all medically necessary services in a timely manner and in the most appropriate setting, thereby achieving the best possible quality outcomes while containing costs.

The Agency awarded contracts to nationally accredited managed care plans that offer comprehensive, quality-driven provider networks, streamlined processes that enhance the enrollee and provider experience, expanded benefits targeted to improve outcomes for enrollees, top quality scores, and high rates of enrollee satisfaction to deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model.

In addition to the objectives stated above, the Agency awarded contracts to managed care plans that offer innovative and evidence-based approaches in meeting the following goals under the Medicaid program:

- Reduce potentially preventable inpatient and outpatient hospital events, and unnecessary ancillary services
- Improve birth outcomes
- Rebalance long-term services and supports systems by increasing the percentage of enrollees receiving services in the community instead of an institution

Project Description:

The State of Florida has offered Medicaid services since 1970. Medicaid is funded by both the State and federal government to provide health care coverage for eligible children, seniors, adults with disabilities, parents of children and pregnant women. The annual budget for the program is more than $25 billion and

makes up the largest part of the total Florida budget. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, Florida Statutes) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: Managed Medical Assistance (MMA) and Long-term Care (LTC). More than 3.2 million Floridians are enrolled in Florida's SMMC program.
Vendor's Involvement: ActiveHealth provides a disease management program, tools, and services; services relating to NCQA accreditation. Active Health, an affiliate of Aetna Better Health of West Virginia, is a clinically based, technology-driven health management services company covering over 20 million enrollees. ActiveHealth has established capabilities, stability, and credibility with nearly 20 years of market leadership and innovation.
Project Benefits: ActiveHealth provides data process and program support for Aetna's disease management program to identify gaps in care and interventions.

Key Personnel	
Name: Mohamed Diab	Role: Chief Executive Officer
Name: Matthew J. Asmus	Role: Chief Financial Officer

Project Measurements:	
Projected Membership of Vendor's Contract: N/A–No projected Membership was identified	Actual Membership of Vendor's Contract: 171,000
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	2/27/2017	To:	Evergreen
Actual Start and Completion Dates:	From:	2/27/2017	To:	Evergreen

Reason(s) for Difference Between Estimated and Actual Dates: N/A
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: ActiveHealth provides a disease management program, tools, and services; services relating to NCQA accreditation.

Aetna Health Management, LLC

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: Aetna Health Management, LLC	Contact Name:	Edward Lee
	Contact Phone:	860-273-3177
Customer Information		
Customer Organization: New Jersey Department of Human Services, Division of Medical Assistance and Health Services	Contact Name:	Jennifer Langer Jacobs
	Contact Title:	Assistant Commissioner, Division of Medical Assistance & Health Services
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-588-2600
	Contact Email:	Jennifer.Jacobs@dhs.state.nj.us

Project Information	
Total Vendor Staff:	All staff of Aetna Health Management are employed by Aetna Resources LLC, an Employee Management Company and Aetna affiliate that provides labor services. Aetna Resources LLC has over 40,000 employees. Staffing assignments are based on staffing needs necessary to meet contract requirements. The number of Aetna Health Management staff that will support any contract awarded as a result of this RFP will be based on the number of staff needed to fulfill our contractual obligations and will be sufficient to meet those obligations.

Project Objectives:

The New Jersey Medicaid FamilyCare program supports well-child care, health promotion, disease prevention, specialty care for those who require such care, diagnostic and intervention strategies, home therapies, and ongoing ancillary services, as well as the long-term management of ongoing medical complications, and continuation of existing relationships with out of network providers when considered to be in the best interest of enrolled children with special health care needs. Aetna Better Health of New Jersey's integrated approach employs best practices for integrating the delivery of care for enrollees, including TANF, CHIP, ABD, and LTSS recipients, throughout the entire continuum of care, including acute care, behavioral health treatment, institutional and facility services, and HCBS.

Project Description:

The New Jersey Medicaid FamilyCare program provides health coverage to children, pregnant women, parents/caretaker relatives, single adults, childless couples, the aged, blind, disabled, and individuals qualified for long-term care services. New Jersey FamilyCare's comprehensive health coverage provides a wide range of services including doctor visits, hospital services, prescriptions, tests, vision care, mental

health care, dental, nursing home care, and other health care services, depending on the person's eligibility category.				
Vendor's Involvement: Aetna Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions. Aetna Health Management has performed services for Medicaid health plans since 2004.				
Project Benefits: Aetna Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions.				
Key Personnel				
Name: Sheryl Burke Adkins – President	Role: President			
Name: Tracy Smith	Role: Vice President and Treasurer			
Project Measurements:				
Projected Membership of Vendor's Contract: 85,000	Actual Membership of Vendor's Contract: 65,643			
Reason(s) for Change in Membership: Statewide membership decrease, partly due to change in state requirements for applicant documentation and partly due to improved state economy				
Estimated Start and Completion Dates:	From:	12/1/2014	To:	Evergreen
Actual Start and Completion Dates:	From:	12/1/2014	To:	Evergreen
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Aetna Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions.				

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Aetna Health Management, LLC	Contact Name:	Edward Lee
	Contact Phone:	860-273-3177
Customer Information		
Customer Organization: Virginia Department of Medical Assistance Services	Contact Name:	Daniel Plain
	Contact Title:	Director, Health Care Services Division
Customer Address: 600 East Broad Street, 11th Floor, Richmond, Virginia 23219	Contact Phone:	804-588-4883
	Contact Email:	Daniel.Plain@dmas.virginia.gov

Project Information	
Total Vendor Staff:	Aetna Health Management has no employees. All staff of Aetna Health Management are employed by Aetna Resources LLC, an Employee Management Company and Aetna affiliate that provides labor services. Aetna Resources LLC has over 40,000 employees. Staffing assignments are based on staffing needs necessary to meet contract requirements. The number of Aetna Health Management staff that will support any contract awarded as a result of this RFP will be based on the number of staff needed to fulfill our contractual obligations and will be sufficient to meet those obligations.

Project Objectives:

The focus of Medallion 4.0 was to evolve from the Medallion 3.0 foundation, engage health systems and stakeholders, provide holistic and integrated care, add new services and populations, provide flexible delivery systems and payment models, and to grow stronger through improved quality, data, and reporting.

The Department of Medical Assistance Services, hereinafter referred to as the Department or DMAS, is the single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Children's Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act. Medallion 4.0 is the next iteration of DMAS's long-standing Medallion II and Medallion 3.0 Medicaid and FAMIS Managed Care Programs and will focus on improving quality, access, and efficiency.

Medallion II was Virginia's first mandatory managed care program. As the program expanded wide (statewide) and deep (additional populations), Medallion II was rebranded Medallion 3.0 with a renewed focus on the areas of systems integration, contract and quality monitoring, compliance, and program

integrity. Virginia seeks to strengthen and reinvigorate this model by adjusting the included populations and services.
Project Description: Medicaid covers 1 in every 3 births in Virginia and almost 1 in 3 children. Virginia Medicaid provides access to medical services, such as: outpatient care (primary or specialty care services); hospital care, nursing facility services, and behavioral health services. Medicaid/FAMIS covers vital health care services like preventive screening, treatment, or care for acute illness, and dental services. Medicaid/FAMIS focuses on giving Virginia's children a healthy start in life by keeping pregnant women healthy. Services for pregnant women include prenatal care, other comprehensive health care services, and dental health.
Vendor's Involvement: Aetna Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions. Aetna Health Management has performed services for Medicaid health plans since 2004.
Project Benefits: Aetna Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions.

Key Personnel	
Name: Sheryl Burke Adkins – President	Role: President
Name: Tracy Smith	Role: Vice President and Treasurer

Project Measurements:	
Projected Membership of Vendor's Contract: N/A–No projected Membership was identified	Actual Membership of Vendor's Contract: 171,000
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	1/1/2014	To:	Evergreen
Actual Start and Completion Dates:	From:	1/1/2014	To:	Evergreen

Reason(s) for Difference Between Estimated and Actual Dates: N/A
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

Aetna Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions.

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Aetna Health Management, LLC	Contact Name:	Edward Lee
	Contact Phone:	860-273-3177
Customer Information		
Customer Organization: Florida Agency for Health Care Administration	Contact Name:	Beth Kidder
	Contact Title:	Deputy Secretary of Medicaid
Customer Address: 2727 Mahan Drive, Mail Stop #8, Tallahassee, Florida 32308	Contact Phone:	850-412-4000
	Contact Email:	Beth.Kidder@ahca.myflorida.com

Project Information	
Total Vendor Staff:	Aetna Health Management has no employees. All staff of Aetna Health Management are employed by Aetna Resources LLC, an Employee Management Company and Aetna affiliate that provides labor services. Aetna Resources LLC has over 40,000 employees. Staffing assignments are based on staffing needs necessary to meet contract requirements. The number of Aetna Health Management staff that will support any contract awarded as a result of this RFP will be based on the number of staff needed to fulfill our contractual obligations and will be sufficient to meet those obligations.

Project Objectives:

The Agency's overall objective is for Medicaid enrollees to receive all medically necessary services in a timely manner and in the most appropriate setting, thereby achieving the best possible quality outcomes while containing costs.

The Agency awarded contracts to nationally accredited managed care plans that offer comprehensive, quality-driven provider networks, streamlined processes that enhance the enrollee and provider experience, expanded benefits targeted to improve outcomes for enrollees, top quality scores, and high rates of enrollee satisfaction to deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model.

In addition to the objectives stated above, the Agency awarded contracts to managed care plans that offer innovative and evidence-based approaches in meeting the following goals under the Medicaid program:

- Reduce potentially preventable inpatient and outpatient hospital events, and unnecessary ancillary services
- Improve birth outcomes

Rebalance long-term services and supports systems by increasing the percentage of enrollees receiving services in the community instead of an institution

Project Description:

The State of Florida has offered Medicaid services since 1970. Medicaid is funded by both the State and federal government to provide health care coverage for eligible children, seniors, adults with disabilities, parents of children and pregnant women. The annual budget for the program is more than $25 billion and makes up the largest part of the total Florida budget. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, Florida Statutes) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: Managed Medical Assistance (MMA) and Long-term Care (LTC). More than 3.2 million Floridians are enrolled in Florida's SMMC program.

Vendor's Involvement:

Aetna Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions. Aetna Health Management has performed services for Medicaid health plans since 2004.

Project Benefits:

Aetna Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions.

Key Personnel	
Name: Sheryl Burke Adkins – President	Role: President
Name: Tracy Smith	Role: Vice President and Treasurer

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 95,768
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	1/1/2014	To:	Evergreen
Actual Start and Completion Dates:	From:	1/1/2014	To:	Evergreen

Reason(s) for Difference Between Estimated and Actual Dates:
N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Aetna Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions.

Aetna Medicaid Administrators, LLC

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: Aetna Medicaid Administrators, LLC	Contact Name:	Mary Louise Osborne
	Contact Phone:	724-778-5984
Customer Information		
Customer Organization: New Jersey Department of Human Services, Division of Medical Assistance and Health Services	Contact Name:	Jennifer Langer Jacobs
	Contact Title:	Assistant Commissioner, Division of Medical Assistance & Health Services
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-588-2600
	Contact Email:	Jennifer.Jacobs@dhs.state.nj.us

Project Information	
Total Vendor Staff:	Over 5,000

Project Objectives:

The New Jersey Medicaid FamilyCare program supports well-child care, health promotion, disease prevention, specialty care for those who require such care, diagnostic and intervention strategies, home therapies, and ongoing ancillary services, as well as the long-term management of ongoing medical complications, and continuation of existing relationships with out of network providers when considered to be in the best interest of enrolled children with special health care needs. Aetna Better Health of New Jersey's integrated approach employs best practices for integrating the delivery of care for enrollees, including TANF, CHIP, ABD, and LTSS recipients, throughout the entire continuum of care, including acute care, behavioral health treatment, institutional and facility services, and HCBS.

Project Description:

The New Jersey Medicaid FamilyCare program provides health coverage to children, pregnant women, parents/caretaker relatives, single adults, childless couples, the aged, blind, disabled, and individuals qualified for long-term care services. New Jersey FamilyCare's comprehensive health coverage provides a wide range of services including doctor visits, hospital services, prescriptions, tests, vision care, mental health care, dental, nursing home care, and other health care services, depending on the person's eligibility category.

Vendor's Involvement:

Aetna Medicaid Administrators employs the nearly 200 staff that support Aetna Better Health of New Jersey. Aetna Medicaid Administrators will provide services for functions that further supports Aetna Better Health of New Jersey performance related to enrollment processing, claims payment, program

integrity monitoring, internal audit, executive oversight, information systems, finance, actuarial, procurement, insurance, risk management, and compliance oversight. Additionally, they will provide oversight and guidance for locally serviced operations such as care and disease management, quality management, and utilization management.

Aetna Medicaid Administrators will provide a streamlined experience for members, providers, and the Department by offering a system of care (SoC) model to improve delivery system capability. A SoC includes a full spectrum of effective, community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and circles of support.

Project Benefits:

Aetna Better Health of New Jersey supports a collaborative model among departments, including utilization management, care management, and behavioral health, to optimize communication to address members' needs within the structure of the benefit. Aetna Better Health of New Jersey excels at care management, which is individualized and addresses the whole member in a model that integrates physical health, behavioral health, and the social determinants of health. This dedication has contributed to Aetna Better Health of New Jersey achieving low rates of hospital readmission, averaging between 5 and 8 percent. The plan's MLTSS Care Management team achieved a $1 million State incentive for MLTSS Quality. Aetna Better Health of New Jersey exceeded the State benchmark for home visits (10 percent of members in care management) by achieving 16 percent. Aetna Better Health of New Jersey received a 91% from IPRO and DMAHS on the annual Medicaid audit in 2018. During the NCQA onsite review ABHNJ received a score of 49 out 50 possible points, attaining full NCQA accreditation.

Key Personnel	
Name: David McNichols	Role: President
Name: Deb Bacon	Role: Chief Operating Officer
Name: Dave Delaney	Role: Chief Financial Officer

Project Measurements:	
Projected Membership of Vendor's Contract: 85,000	Actual Membership of Vendor's Contract: 65,643

Reason(s) for Change in Membership:

Statewide membership decrease, partly due to change in state requirements for applicant documentation and partly due to improved state economy

Estimated Start and Completion Dates:	From:	12/1/2014	To:	Evergreen
Actual Start and Completion Dates:	From:	12/1/2014	To:	Evergreen

Reason(s) for Difference Between Estimated and Actual Dates:

N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Aetna Medicaid Administrators provides executive oversight, disease-management shared services, quality management, utilization management, enrollment processing, claims payment administration, program-integrity monitoring, internal audit, information systems, finance, actuarial, insurance, risk management, and compliance oversight and monitoring, among other functions.

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Aetna Medicaid Administrators, LLC	Contact Name:	Mary Louise Osborne
	Contact Phone:	724-778-5984
Customer Information		
Customer Organization: Virginia Department of Medical Assistance Services	Contact Name:	Daniel Plain
	Contact Title:	Director, Health Care Services Division
Customer Address: 600 East Broad Street, 11th Floor, Richmond, Virginia 23219	Contact Phone:	804-588-4883
	Contact Email:	Daniel.Plain@dmas.virginia.gov
Project Information		
Total Vendor Staff:	Over 5,000	

Project Objectives:

The focus of Medallion 4.0 was to evolve from the Medallion 3.0 foundation, engage health systems and stakeholders, provide holistic and integrated care, add new services and populations, provide flexible delivery systems and payment models, and to grow stronger through improved quality, data, and reporting.

The Department of Medical Assistance Services, hereinafter referred to as the Department or DMAS, is the single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Children's Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act. Medallion 4.0 is the next iteration of DMAS's long-standing Medallion II and Medallion 3.0 Medicaid and FAMIS Managed Care Programs and will focus on improving quality, access, and efficiency.

Medallion II was Virginia's first mandatory managed care program. As the program expanded wide (statewide) and deep (additional populations), Medallion II was rebranded Medallion 3.0 with a renewed

focus on the areas of systems integration, contract and quality monitoring, compliance, and program integrity. Virginia seeks to strengthen and reinvigorate this model by adjusting the included populations and services.

Project Description:

Aetna Better Health of Virginia is licensed as an HMO and as a Managed Care Health Insurance Plan in the State of Virginia. Aetna Better Health of Virginia is also an NCQA-accredited Medicaid health plan.

Aetna Better Health of Virginia has more than 20 years of experience in serving Virginia Medicaid recipients. This long-standing relationship has allowed us to understand, build, and foster relationships with our communities to facilitate fully integrated systems of care and offer a consumer-centric delivery system of care for our members.

With over 465 dedicated employees throughout the Commonwealth, Aetna Better Health of Virginia continues to invest time and support in our members, in an effort to change behaviors, follow their physician's treatment recommendations and adopt healthier lifestyles. Aetna Better Health of Virginia understands that each member is unique, which is why we collaborate to deliver individualized, person-centered care to each of our members. We do this by caring for, empathizing with, listening to, planning for, and educating enrollees to reach a common understanding of trust and shared goals to reduce health disparities and promote health population.

Aetna Better Health of Virginia has developed and managed a robust provider network in the Commonwealth, capable of meeting the health care needs of our members in an accessible, timely, and convenient manner in all six regions. Our provider network is the foundation to our fully integrated systems and is designed to support members in providing a seamless system of services.

The scope of Medallion 4.0 includes medical, behavioral health, pharmacy, vision, and non-emergency medical transportation. Populations include pregnant women, infants, children, low-income adults, children/youth with special health care needs, children in foster care, and individuals formerly in foster care, and individuals receiving SSI.

Medicaid covers 1 in every 3 births in Virginia and almost 1 in 3 children. Virginia Medicaid provides access to medical services, such as: outpatient care (primary or specialty care services); hospital care, nursing facility services, and behavioral health services. Medicaid/FAMIS covers vital health care services like preventive screening, treatment, or care for acute illness, and dental services. Medicaid/FAMIS focuses on giving Virginia's children a healthy start in life by keeping pregnant women healthy. Services for pregnant women include prenatal care, other comprehensive health care services, and dental health.

Vendor's Involvement:

Aetna Medicaid Administrators employs the more than 500 staff that support Aetna Better Health of Virginia. Aetna Medicaid Administrators will provide services for functions that further supports Aetna Better Health of New Jersey performance related to enrollment processing, claims payment, program integrity monitoring, internal audit, executive oversight, information systems, finance, actuarial, procurement, insurance, risk management, and compliance oversight. Additionally, they will provide oversight and guidance for locally serviced operations such as care and disease management, quality management, and utilization management.

Aetna Medicaid Administrators will provide a streamlined experience for members, providers, and the Department by offering a system of care (SoC) model to improve delivery system capability. A SoC includes a full spectrum of effective, community-based physical, behavioral, and oral health care

treatment services along with psychosocial services and supports for individuals, their families, and circles of support.
Project Benefits: The scope of Medallion 4.0 includes medical, behavioral health, pharmacy, vision, and non-emergency medical transportation. Fully Integrated System of Care and Integrated Care Management: Our members are best served by a holistic approach that incorporates a coordinated network of physical and behavioral health care providers, as well as community-based organizations. Our integrated care management program and care coordination system—the cornerstone of our approach for the Medallion 4.0 program—facilitates collaboration among members, practitioners, providers, care coordinators, family members, the member's circle of support, community organizations, and existing case management entities, thus resulting in a seamless system of services. Aetna Better Health of Virginia works to understand each member's readiness to change, individual preferences and goals, and physical and behavioral health care needs. We assess family and community supports, strengths, and any barriers affecting the member's access to care. In doing so, we help each member achieve his or her goals and optimize his or her level of self-care and independence. Our fully integrated system of care is specifically designed to manage members with complex needs. Aetna Better Health of Virginia uses analytic methods to identify our most biopsychosocially complex and vulnerable members for whom we have an opportunity to make a significant difference. Simply stated, health care occurs beyond the boundaries of clinical care settings. With a community-focused population health approach, Aetna Better Health of Virginia is addressing social determinants of health in a meaningful way and providing locally tailored solutions that integrate community initiatives with the health care delivery system. We assess social determinants of health by capturing data through multiple mechanisms including health risk assessments, condition specific assessments, existing care plans, gaps-in-care reports, reports through our health care equity dashboard, predictive modeling, care coordination claims data, provider feedback, community health workers, community and advocate outreach, member surveys, member advocacy committees, and focus groups. Our health care equity dashboard tracks utilization and identifies members who may benefit from additional interventions and education. It also provides inpatient and emergency department usage by gender, age, race, ethnicity, and county. Similarly, providers access real-time admission, discharge, and transfer information for emergency department, inpatient, and outpatient utilization at the individual member level in collaboration with the Commonwealths Emergency Departments Information Exchange program, Pre-Merge.

Key Personnel	
Name: David McNichols	Role: President
Name: Deb Bacon	Role: Chief Operating Officer
Name: Dave Delaney	Role: Chief Financial Officer
Project Measurements:	
Projected Membership of Vendor's Contract:	Actual Membership of Vendor's Contract:

N/A–No projected Membership was identified		171,000		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	3/28/2016	To:	Evergreen
Actual Start and Completion Dates:	From:	3/28/2016	To:	Evergreen
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: **Aetna Medicaid Administrators provides executive oversight, disease-management shared services,** quality management, utilization management, enrollment processing, claims payment administration, program-integrity monitoring, internal audit, information systems, finance, actuarial, insurance, risk management, and compliance oversight and monitoring, among other functions.				

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Aetna Medicaid Administrators, LLC	Contact Name:	Mary Louise Osborne
	Contact Phone:	724-778-5984
Customer Information		
Customer Organization: Florida Agency for Health Care Administration	Contact Name:	Beth Kidder
	Contact Title:	Deputy Secretary of Medicaid
Customer Address: 2727 Mahan Drive, Mail Stop #8, Tallahassee, FL 32308	Contact Phone:	850-412-4000
	Contact Email:	Beth.Kidder@ahca.myflorida.com
Project Information		
Total Vendor Staff:	Over 5,000	
Project Objectives:		

The Agency's overall objective is for Medicaid enrollees to receive all medically necessary services in a timely manner and in the most appropriate setting, thereby achieving the best possible quality outcomes while containing costs.

The Agency awarded contracts to nationally accredited managed care plans that offer comprehensive, quality-driven provider networks, streamlined processes that enhance the enrollee and provider experience, expanded benefits targeted to improve outcomes for enrollees, top quality scores, and high rates of enrollee satisfaction to deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model.

In addition to the objectives stated above, the Agency awarded contracts to managed care plans that offer innovative and evidence-based approaches in meeting the following goals under the Medicaid program:

- Reduce potentially preventable inpatient and outpatient hospital events, and unnecessary ancillary services
- Improve birth outcomes
- Rebalance long-term services and supports systems by increasing the percentage of enrollees receiving services in the community instead of an institution

Project Description:

The State of Florida has offered Medicaid services since 1970. Medicaid is funded by both the State and federal government to provide health care coverage for eligible children, seniors, adults with disabilities, parents of children and pregnant women. The annual budget for the program is more than $25 billion and makes up the largest part of the total Florida budget. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, Florida Statutes) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: Managed Medical Assistance (MMA) and Long-term Care (LTC). More than 3.2 million Floridians are enrolled in Florida's SMMC program.

Vendor's Involvement:

Aetna Medicaid Administrators provides the approximately 350 staff that support Aetna Better Health of Florida staff members. Aetna Medicaid Administrators will provide services for functions that further supports Aetna Better Health of New Jersey performance related to enrollment processing, claims payment, program integrity monitoring, internal audit, executive oversight, information systems, finance, actuarial, procurement, insurance, risk management, and compliance oversight. Additionally, they will provide oversight and guidance for locally serviced operations such as care and disease management, quality management, and utilization management.

Aetna Medicaid Administrators will provide a streamlined experience for members, providers, and the Department by offering a system of care (SoC) model to improve delivery system capability. A SoC includes a full spectrum of effective, community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and circles of support.

Project Benefits:

The SMMC program covers a range of services including outpatient, hospital, behavioral health, substance abuse, community case management, targeted care management, transportation, pharmacy, Nursing Home and Assisted Living Facility Services, medical foster care, vision, and family planning.

Aetna Better Health of Florida works closely and collaboratively with our provider networks to integrate our innovative solutions in ways that complement their existing technology and health care service delivery goals. Specific offerings include a progressive payment model, innovative data-sharing

technology, care management and care coordination resources, and technical support that work in concert to align across the care continuum. Aetna's progressive approach to driving high-quality, positive outcomes gives providers an array of payment arrangements for increasing clinical and financial complexity and sophistication in risk-sharing.

This integrated approach has helped us to improve care and achieve high levels of provider satisfaction, including decreasing readmissions by 18% in 2018-2019, decreasing emergency room use by 14%, and achieving 86% provider satisfaction scores in 2019.

Key Personnel	
Name: David McNichols	Role: President
Name: Deb Bacon	Role: Chief Operating Officer
Name: Dave Delaney	Role: Chief Financial Officer

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 95,768
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	2/27/2017	To:	Evergreen
Actual Start and Completion Dates:	From:	2/27/2017	To:	Evergreen

Reason(s) for Difference Between Estimated and Actual Dates:
N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

Aetna Medicaid Administrators provides executive oversight, disease-management shared services, quality management, utilization management, enrollment processing, claims payment administration, program-integrity monitoring, internal audit, information systems, finance, actuarial, insurance, risk management, and compliance oversight and monitoring, among other functions.

Center for the Study of Services

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: Center for the Study of Services (CSS)	Contact Name:	Jackie Pearce Garrett, Director of Business Development, Center for the Study of Services
	Contact Phone:	202-454-3041
Customer Information		
Customer Organization: Oregon Health Authority, Health Policy & Analytics Division	Contact Name:	Jennifer Davis
	Contact Title:	Policy Analyst / Project Manager
Customer Address: 500 Summer Street NE, E-20, Salem, OR 97301-1097	Contact Phone:	503-593-4680
	Contact Email:	Jennifer.c.davis@dhsoha.state.or.us
Project Information		
Total Vendor Staff:	22	
Project Objectives: The Oregon Health Plan provides health care coverage for low-income Oregonians from all walks of life. This includes working families, children, pregnant women, single adults, and seniors. Oregon Health Authority oversees the activities of 16 coordinated care organizations (CCOs). The goal of this project is to measure Medicaid member experience.		
Project Description: The project includes administering three CAHPS surveys for each CCO: adult Medicaid, child Medicaid with chronic conditions, and child Medicaid without chronic conditions and reporting survey results to both the state and the CCOs. Oregon does not adhere to the NCQA protocol allowing them some flexibility in sampling, fielding protocol, and timeline.		
Vendor's Involvement: CSS's responsibilities include developing and designing survey materials in both English and Spanish; Processing the sample frame and drawing the survey sample; Reaching out to sample members using mail and telephone; Collecting, cleaning and processing survey responses; Analyzing and reporting results to help the state and the CCOs identify performance differences and identify opportunities for improvement. CSS also provides advice to help the state make fielding decisions given the flexibility they have in this project.		
Project Benefits:		

The project provides information to individual CCOs to support quality improvement efforts. The project also provides information to the state that is used to manage the effectiveness of the program and to help consumers make informed decisions when comparing CCOs.				
Key Personnel				
Name: Mike Parks		Role: Survey Director and Project Manager		
Name: Kevin Fomalont		Role: Research Associate		
Project Measurements:				
Projected Membership of Vendor's Contract: This is not applicable. CSS surveys a randomly selected preset number of people. Projected and actual membership counts are not relevant.		Actual Membership of Vendor's Contract: This is not applicable. CSS surveys a randomly selected preset number of people. Projected and actual membership counts are not relevant.		
Reason(s) for Change in Membership: This is not applicable. CSS surveys a randomly selected preset number of people. Projected and actual membership counts are not relevant.				
Estimated Start and Completion Dates:	From:	10/1/2017	To:	9/30/2020
Actual Start and Completion Dates:	From:	10/1/2017	To:	ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: CSS provides member surveys.				

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Center for the Study of Services (CSS)	Contact Name:	Jackie Pearce Garrett, Director of Business Development, Center for the Study of Services
	Contact Phone:	202-454-3041

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Customer Information		
Customer Organization: Maryland Department of Health, Division of HealthChoice Quality Assurance	Contact Name:	Monchel Pridget
	Contact Title:	Acting Chief, Division of HealthChoice Quality Assurance
Customer Address: 201 W. Preston Street, Room 208E Baltimore, MD 21201	Contact Phone:	410.767.5946
	Contact Email:	monchel.pridget@maryland.gov

Project Information	
Total Vendor Staff:	22

Project Objectives:

HealthChoice is Maryland's Medicaid managed care program. HealthChoice oversees the activities of nine Managed Care Organizations. The Maryland Department of Health also administers the Rare and Expensive Case Management (REM) Program. The goal of this project is to measure Medicaid member experience with the programs and to measure provider experience with HealthChoice MCOs.

Project Description:

The project includes (1) administering two NCQA HEDIS CAHPS surveys for each HealthChoice MCO – adult Medicaid and child Medicaid with chronic conditions, reporting survey results to both the state and the MCOs; (2) developing and administering an REM experience survey for both adults and children and reporting results to the state; (3) developing, administering, and reporting on the results of a survey of PCPs to measure their satisfaction with MCOs.

Vendor's Involvement:

CSS's responsibilities include developing and designing survey materials in both English and Spanish; processing the sample frame and drawing the survey sample; reaching out to sample members using mail, telephone, and email; collecting, cleaning, and processing survey responses; analyzing and reporting results to help the state and the MCOs identify performance differences and identify opportunities for improvement.

Project Benefits:

The project provides information to individual MCOs to support accreditation and quality improvement efforts. The project also provides information to the state that is used to manage the effectiveness of the program and to help consumers make informed decisions when comparing MCOs.

Key Personnel	
Name: Paul Kallaur	Role: Vice President of Surveys and Research
Name: Alok Shrestha	Role: Sr. Research Associate and Project Manager
Name: Michelle Eckstein	Role: Research Associate

Project Measurements:	
Projected Membership of Vendor's Contract: This is not applicable. CSS surveys a randomly **selected preset number of people. Projected** and actual membership counts are not relevant.	Actual Membership of Vendor's Contract: This is not applicable. CSS surveys a randomly selected preset **number of people. Projected and actual membership** counts are not relevant.
Reason(s) for Change in Membership: This is not applicable. CSS surveys a randomly selected preset number of people. Projected and actual membership counts are not relevant.	

Estimated Start and Completion Dates:	From:	10/1/2017	To:	9/30/2022
Actual Start and Completion Dates:	From:	10/1/2017	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

Annual member and provider surveys.

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Center for the Study of Services (CSS)	Contact Name:	Jackie Pearce Garrett, Director of Business Development, Center for the Study of Services
	Contact Phone:	202-454-3041
Customer Information		
Customer Organization: Aetna Better Health	Contact Name:	Charlene Blanchard
	Contact Title:	Health Care QM Project Manager, Aetna Medicaid, National Quality Management
Customer Address: 4500 E Cotton Center Blvd, Phoenix, AZ 85040	Contact Phone:	602-453-6190
	Contact Email:	BlanchardC2@AETNA.com
Project Information		
Total Vendor Staff:	**22**	

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Project Objectives: The goal of this project is to measure Medicaid member experience with Aetna Better Health plans and conduct the survey to ensure the NCQA HEDIS standards are met.
Project Description: The project includes (1) administering NCQA HEDIS CAHPS surveys for adult Medicaid, child Medicaid, and child Medicaid with chronic conditions, and reporting survey results] to the plans; (2) Submitting survey results to NCQA and state agencies as requested by Aetna Better Health in the agreed upon format.
Vendor's Involvement: CSS's responsibilities include developing and designing survey materials in both English and Spanish; processing the sample frame and drawing a sample following NCQA guidelines; Reaching out to sample members using mail and telephone; Collecting, cleaning and processing survey responses; Analyzing and reporting results to the plan identify performance differences and identify opportunities for improvement; and submitting the data to NCQA and other entities as dictated by the Aetna Better Health.
Project Benefits: The project provides information to plans to support accreditation, state requirements, and quality improvement efforts.

Key Personnel	
Name: Paul Kallaur	Role: Vice President of Surveys and Research
Name: Eban Lewis	Role: Sr. Research Associate and Project Manager

Project Measurements:	
Projected Membership of Vendor's Contract: This is not applicable. CSS surveys a randomly selected preset number of people. Projected and actual membership counts are not relevant	Actual Membership of Vendor's Contract: This is not applicable. CSS surveys a randomly selected preset number of people. Projected and actual membership counts are not relevant
Reason(s) for Change in Membership: This is not applicable. CSS surveys a randomly selected preset number of people. Projected and actual membership counts are not relevant	

Estimated Start and Completion Dates:	From:	10/1/2014	To:	9/30/2020
Actual Start and Completion Dates:	From:	10/1/2014	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: CSS provides member surveys.

Change Health

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: Change Healthcare	Contact Name:	Ann Armstrong
	Contact Phone:	414-405-8651
Customer Information		
Customer Organization: Mercy Care	Contact Name:	Dena Steinbach
	Contact Title:	Network Relations Manager
Customer Address: 4755 S 44th Place Phoenix, AZ 85040	Contact Phone:	602-453-6194
	Contact Email:	SteinbachD@MercyCareAZ.org
Project Information		
Total Vendor Staff:	Operational, IT, Account Management and Sales resources work to support Aetna Medicaid and plans around the solutions outlined. >100	
Project Objectives: CHC's work with Aetna Medicaid health plans is not project specific. Some objectives include; delivering timely HIPAA-compliant EDI claim files to Aetna Medicaid and health plans, and processing ERA/EFT transactions in accordance with the elapsed time standards detailed in the CAQH CORE Phase III Operating Rules for Information Exchange of EFT and ERA.		
Project Description: CHC's work with Aetna Medicaid health plans is not project specific. Some objectives include; delivering timely HIPAA-compliant EDI claim files to Aetna Medicaid and health plans, and processing ERA/EFT transactions in accordance with the elapsed time standards detailed in the CAQH CORE Phase III Operating Rules for Information Exchange of EFT and ERA.		
Vendor's Involvement: Management and oversight of relationship and operational processes.		
Project Benefits: CHC's solutions help Aetna Medicaid plans reduce administrative costs, streamline provider payment distribution, reduce paper claims, and improve the provider experience.		
Key Personnel		
Name: Ann Armstrong	Role: Senior Client Executive - oversees relationship	
Name: Urban Petersen	Role: Manager, Client Services Payment Distribution	
Name: Teres Atkinson	Role: Client Executive - oversees Payment operations	

Name: Lynn Johnson		Role: Client Executive – oversees EDI Claims/RT operations		
Project Measurements:				
Projected Membership of Vendor's Contract: None. Membership not part of contract. Approximately 47,700		Actual Membership of Vendor's Contract: None Membership not part of contract. Approximately 47,700		
Reason(s) for Change in Membership: None				
Estimated Start and Completion Dates:	From:	5/2005	To:	Ongoing
Actual Start and Completion Dates:	From:	5/2005	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: None				
If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: • Receipt/routing of Provider EDI Claims and Real-time transaction requests to Aetna Medicaid. • Receipt of payment files from Aetna Medicaid and distribution of both electronic and paper payments and remittance advice to health plan providers. • Portal solution allows health plan to offer no-cost EDI claim submission for providers through the plan website				

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Change Healthcare	Contact Name:	Ann Armstrong
	Contact Phone:	414-405-8651
Customer Information		
Customer Organization: Aetna Better Health of Virginia	Contact Name:	Hasani Jackson
	Contact Title:	Manager, Provider Relations
Customer Address: 9881 Mayland Drive	Contact Phone:	(804) 527-6405

Richmond, VA 23233		Contact Email:	JacksonH@Aetna.com

Project Information	
Total Vendor Staff:	Operational, IT, Account Management and Sales resources work to support Aetna Medicaid and plans around the solutions outlined. >100

Project Objectives:

CHC's work with Aetna Medicaid health plans is not project specific. Some objectives include; delivering timely HIPAA-compliant EDI claim files to Aetna Medicaid and health plans, and processing ERA/EFT transactions in accordance with the elapsed time standards detailed in the CAQH CORE Phase III Operating Rules for Information Exchange of EFT and ERA.

Project Description:

CHC's work with Aetna Medicaid health plans is not project specific. Contracted services include the following:

- Receipt/routing of Provider EDI Claims and Real-time transaction requests to Aetna Medicaid.
- Receipt of payment files from Aetna Medicaid and distribution of both electronic and paper payments and remittance advice to health plan providers.

Portal solution allows health plan to offer no-cost EDI claim submission for providers through the plan website.

Vendor's Involvement: Management and oversight of relationship and operational processes.

Project Benefits: Not project specific. CHC's solutions help Aetna Medicaid plans reduce administrative costs, streamline provider payment distribution, reduce paper claims, and improve the provider experience.

Key Personnel	
Name: Ann Armstrong	Role: Senior Client Executive-oversees business relationship
Name: Urban Petersen	Role: Manager, Client Services Payment Distribution
Name: Teres Atkinson	Role: Client Executive - oversees Payment operations
Name: Lynn Johnson	Role: Client Executive – oversees EDI Claims/RT operations

Project Measurements:	
Projected Membership of Vendor's Contract: None Membership not part of contract. Approximately 164,100	Actual Membership of Vendor's Contract: None Membership not part of contract. Approximately 164,100
Reason(s) for Change in Membership: None – Membership is not part of contract.	

Estimated Start and Completion Dates:	From:	4/2014	From:	Ongoing

Actual Start and Completion Dates:	From:	4/2014	From:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: None				

If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities:

- Receipt/routing of Provider EDI Claims and Real-time transaction requests to Aetna Medicaid.
- Receipt of payment files from Aetna Medicaid and distribution of both electronic and paper payments and remittance advice to health plan providers.
- Portal solution allows health plan to offer no-cost EDI claim submission for providers through the plan website

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Change Healthcare	Contact Name:	Ann Armstrong
	Contact Phone:	414-405-8651
Customer Information		
Customer Organization: Aetna Better Health of Michigan	Contact Name:	Margaret Campbell
	Contact Title:	Manager, Provider Relations
Customer Address: 1333 Brewery Park Blvd #400 Detroit, MI 48207	Contact Phone:	(959) 230-8634
	Contact Email:	CampbellM10@aetna.com
Project Information		
Total Vendor Staff:	Operational, IT, Account Management and Sales resources work to support Aetna Medicaid and plans around the solutions outlined. >100	
Project Objectives: CHC's work with Aetna Medicaid health plans is not project specific. Some objectives include; delivering timely HIPAA-compliant EDI claim files to Aetna Medicaid and health plans, and processing ERA/EFT transactions in accordance with the elapsed time standards detailed in the CAQH CORE Phase III Operating Rules for Information Exchange of EFT and ERA.		
Project Description: CHC's work with Aetna Medicaid health plans is not project specific. Contracted services include the following:		

• Receipt/routing of Provider EDI Claims and Real-time transaction requests to Aetna Medicaid. • Receipt of payment files from Aetna Medicaid and distribution of both electronic and paper payments and remittance advice to health plan providers. Portal solution allows health plan to offer no-cost EDI claim submission for providers through the plan website.				
Vendor's Involvement: Management and oversight of relationship and operational processes.				
Project Benefits: Not project specific. CHC's solutions help Aetna Medicaid plans reduce administrative costs, streamline provider payment distribution, reduce paper claims, and improve the provider experience.				
Key Personnel				
Name: Ann Armstrong	Role: Senior Client Executive-oversees business relationship			
Name: Urban Petersen	Role: Manager, Client Services Payment Distribution			
Name: Teres Atkinson	Role: Client Executive - oversees Payment operations			
Name: Lynn Johnson	Role: Client Executive – oversees EDI Claims/RT operations			
Project Measurements:				
Projected Membership of Vendor's Contract: None Membership not part of contract. Approximately 47,700	Actual Membership of Vendor's Contract: None Membership not part of contract. Approximately 47,700			
Reason(s) for Change in Membership: None – Membership is not part of contract.				
Estimated Start and Completion Dates: None	From:	4/2014	From:	Ongoing
Actual Start and Completion Dates: None	From:	4/2014	From:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: None				
If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: • Receipt/routing of Provider EDI Claims and Real-time transaction requests to Aetna Medicaid. • Receipt of payment files from Aetna Medicaid and distribution of both electronic and paper payments and remittance advice to health plan providers. • Portal solution allows health plan to offer no-cost EDI claim submission for providers through the plan website				

Cotiviti

Table 9: Subcontractor References #1

Vendor Information		
Vendor Name: Cotiviti, Inc. (representing itself and its subsidiaries and affiliates)	Contact Name:	Lori Walsh
	Contact Phone:	770-379-2360
Customer Information		
Customer Organization: Aetna Better Health of Texas	Contact Name:	Cheryl Harding
	Contact Title:	CEO
Customer Address: 2777 Stemmons Fwy, Dallas, TX 75207	Contact Phone:	214-200-8226
	Contact Email:	HardingC2@Aetna.com
Project Information		
Total Vendor Staff:	**20-100 varies depending on the project scope**	
Project Objectives: Payment Accuracy/Billing Accuracy		
Project Description: Prospective Claim Accuracy		
Vendor's Involvement: Prospective Claims Accuracy activities		
Project Benefits: Avoid payment errors before claim gets paid		
Key Personnel		
Name: Lori Walsh	Role: Client Engagement Lead	
Name: Gwin Teasdale	Role: SVP, Client Engagement	
Project Measurements:		
Projected Membership of Vendor's Contract: Approximately 259,600	Actual Membership of Vendor's Contract: Approximately 259,600	
Reason(s) for Change in Membership: N/A		

Estimated Start and Completion Dates:	From:	2004	To:	current
Actual Start and Completion Dates:	From:	2004	To:	current
Reason(s) for Difference Between Estimated and Actual Dates: n/a				
If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: Cotiviti's billing accuracy solution enables payers to make informed, data-driven, clinically centered decisions on payment policy. Our unique insights leverage extensive reference assets and clinical research acumen to help us identify potential payment vulnerabilities and develop industry-compliant, effective payment rules. Our comprehensive policy recommendations apply across all provider settings and lines of business.				

Table 9: Subcontractor References #2

Vendor Information		
Vendor Name: Cotiviti, Inc. (representing itself and its subsidiaries and affiliates)	Contact Name:	Susan Murray
	Contact Phone:	475-393-6058
Customer Information		
Customer Organization: Aetna Better Health of Kansas	Contact Name:	David Livingston
	Contact Title:	VP, Medicaid Health Plan
Customer Address: 9401 Indian Creek Parkway, Suite 1300, Overland Park, KS 66210	Contact Phone:	785-596-8233
	Contact Email:	livingston@aetna.com
Project Information		
Total Vendor Staff:	**20-100 varies depending on project scope**	
Project Objectives: Payment Accuracy/Retrospective Claims Accuracy		
Project Description: Retrospective Claims Accuracy		
Vendor's Involvement:		

Retrospective Claims Accuracy activities.				
Project Benefits: Improper claim identification and recovery.				
Key Personnel				
Name: Susan Murray		Role: Client Engagement Lead		
Name: Gwin Teasdale		Role: SVP, Client Engagement		
Project Measurements:				
Projected Membership of Vendor's Contract: Approximately 103, 250		Actual Membership of Vendor's Contract: Approximately 103, 250		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	2004	To:	current
Actual Start and Completion Dates:	From:	2004	To:	current
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Cotiviti's billing accuracy solution enables payers to make informed, data-driven, clinically centered decisions on payment policy. Our unique insights leverage extensive reference assets and clinical research acumen to help us identify potential payment vulnerabilities and develop industry-compliant, effective payment rules. Our comprehensive policy recommendations apply across all provider settings and lines of business.				

Table 9: Subcontractor References #3

Vendor Information		
Vendor Name: Cotiviti, Inc. (representing itself and its subsidiaries and affiliates)	Contact Name:	Susan Murray
	Contact Phone:	475-393-6058
Customer Information		
Customer Organization: Aetna Better Health of Kentucky	Contact Name:	Jonathan Copley

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	Contact Title:	CEO
Customer Address: 9900 Corporate Campus Dr #1000, Louisville, KY 40223	Contact Phone:	502-622-7577
	Contact Email:	CopleyJ@aetna.com

Project Information	
Total Vendor Staff:	**20-100 varies depending on project scope**
Project Objectives: Payment Accuracy/Clinical Chart Validation	
Project Description: Clinical Chart Validation	
Vendor's Involvement: Clinical Chart Validation activities.	
Project Benefits: Improper claim identification and recovery.	

Key Personnel	
Name: Susan Murray	Role: Client Engagement Lead
Name: Gwin Teasdale	Role: SVP, Client Engagement

Project Measurements:	
Projected Membership of Vendor's Contract: Approximately 216,800	Actual Membership of Vendor's Contract: Approximately 216,800
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	2004	To:	current
Actual Start and Completion Dates:	From:	2004	To:	current

Reason(s) for Difference Between Estimated and Actual Dates: N/A
If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities:

Reviewing clinical charts to validate that key diagnoses and procedures on claims are properly supported is costly and time-consuming. Much of the data is unstructured, such as handwritten physician's notes. Reviews require validating hundreds or even thousands of pages of information. When payers concentrate on reviewing as many charts as possible, they waste time and resources while risking their provider relationships. In addition, although coding errors and documentation issues are important to catch, they do not always add up to high-dollar overpayments.

Cotiviti's clinical chart validation solution goes beyond coding and documentation review to find more value with fewer charts, reduce unnecessary provider requests, and keep costs sustainable.

CQ fluency, Inc.

Table 9: Subcontractor References #1

Vendor Information		
Vendor Name: CQ fluency	Contact Name:	Alan Vernon
	Contact Phone:	201-487-8007
Customer Information		
Customer Organization: Maryland Department of Health and Mental Hygiene	Contact Name:	Susan Tucker
	Contact Title:	Executive Director
Customer Address: 201 W. Preston St, Baltimore, MD 21201	Contact Phone:	410-767-1430
	Contact Email:	Susan.Tucker@Maryland.gov
Project Information		
Total Vendor Staff:	**3**	
Project Objectives: Accurately translated and 508 compliant documents		
Project Description: Translate and remediate for 508 compliance all documents supporting Aetna Better Health of Maryland		
Vendor's Involvement: Translate, edit, proofread, and remediate all documents and deliver within specified deadlines		
Project Benefits: Improved access to information for members of Aetna Better Health of Maryland		
Key Personnel		
Name: Leah Spielholz	Role: Project Manager	
Name: Marcel Yang	Role: Director of Production	
Project Measurements:		
Projected Membership of Vendor's Contract: Approximately 27,975	Actual Membership of Vendor's Contract: Approximately 27,975	
Reason(s) for Change in Membership: N/A		

Estimated Start and Completion Dates:	From:	6/2013	To:	Ongoing
Actual Start and Completion Dates:	From:	6/2013	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: Translate and remediate for 508 compliance all documents supporting Aetna Better Health of Maryland				

Table 9: Subcontractor References #2

Vendor Information		
Vendor Name: CQ fluency	Contact Name:	Alan Vernon
	Contact Phone:	201-487-8007
Customer Information		
Customer Organization: New York Department of Health	Contact Name:	Mark Kissinger
	Contact Title:	Director, Division of Long-Term Care
Customer Address: Room 1415, Empire State Plaza, Albany 12237	Contact Phone:	518-402-5673
	Contact Email:	Mark.Kissinger@health.state.ny.us
Project Information		
Total Vendor Staff:	3	
Project Objectives: Accurately translated and 508 compliant documents		
Project Description: Translate and remediate for 508 compliance all documents supporting Aetna Better Health of New York		
Vendor's Involvement: Translate, edit, proofread, and remediate all documents and deliver within specified deadlines		
Project Benefits: Improved access to information for members of Aetna Better Health of New York		

Key Personnel				
Name: Leah Spielholz		Role: Project Manager		
Name: Marcel Yang		Role: Director of Production		
Project Measurements:				
Projected Membership of Vendor's Contract: Approximately 8,200		Actual Membership of Vendor's Contract: Approximately 8,200		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	6/2013	To:	ongoing
Actual Start and Completion Dates:	From:	6/2013	To:	ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: Translate and remediate for 508 compliance all documents supporting Aetna Better Health of New York				

Table 9: Subcontractor References #3

Vendor Information		
Vendor Name: CQ fluency	Contact Name:	Alan Vernon
	Contact Phone:	201-487-8007
Customer Information		
Customer Organization: Ohio Department of Medicaid/Centers for Medicare and Medicaid	Contact Name:	Amanda Gillespie
	Contact Title:	Contract Administrator
Customer Address: 50 West Town Street, Columbus, OH 43215	Contact Phone:	614-752-5552
	Contact Email:	Amanda.Gillespie@medicaid.ohio.gov

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Project Information	
Total Vendor Staff:	**3**
Project Objectives: Accurately translated and 508 compliant documents	
Project Description: Translate and remediate for 508 compliance all documents supporting Aetna Better Health of Ohio	
Vendor's Involvement: Translate, edit, proofread, and remediate all documents and deliver within specified deadlines	
Project Benefits: Project Benefits: Improved access to information for members of Aetna Better Health of Ohio	

Key Personnel	
Name: Leah Spielholz	Role: Project Manager
Name: Marcel Yang	Role: Director of Production

Project Measurements:	
Projected Membership of Vendor's Contract: Approximately 25,500	Actual Membership of Vendor's Contract: Approximately 25,500
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	6/2013	To:	ongoing
Actual Start and Completion Dates:	From:	6/2013	To:	ongoing

Reason(s) for Difference Between Estimated and Actual Dates: N/A
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Translate and remediate for 508 compliance all documents supporting Aetna Better Health of Ohio

Equian, LLC

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: Equian, LLC	Contact Name:	Stephanie Elliot
	Contact Phone:	720-259-4367
Customer Information		
Customer Organization: Michigan Department of Health and Human Services	Contact Name:	Dan Voss
	Contact Title:	Manager, Legal Liability and Recovery Section Third Party Liability Division
Customer Address: 201 Townsend Street Seventh Floor Lansing, Michigan 48913	Contact Phone:	517.335.7506
	Contact Email:	VossD@michigan.gov
Project Information		
Total Vendor Staff:	**1,900**	
Project Objectives: Third Party Liability – provide state reporting representing efforts of subrogation for MCO		
Project Description: Subrogation – Delivery quarterly reports with third party liability recovery detail		
Vendor's Involvement: Subrogation – Attend quarterly calls and provide detailed reports		
Project Benefits: Meets contractual requirements between MCO and State of Michigan - DHHS		
Key Personnel		
Name: Josh Holmberg	Role: Director, Account Management	
Project Measurements:		
Projected Membership of Vendor's Contract: Equian does not have a direct contract with the State of Michigan – 1,549, 597 Lives	Actual Membership of Vendor's Contract: Equian does not have a direct contract with the State of Michigan – 1,549, 597 Lives	
Reason(s) for Change in Membership:		

N/A				
Estimated Start and Completion Dates:	From:	2008	To:	Ongoing
Actual Start and Completion Dates:	From:	2008	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Subrogation - Equian provides end to end payment integrity solutions and operates worldwide.				

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Equian, LLC	Contact Name:	Stephanie Elliot
	Contact Phone:	720-259-4367
Customer Information		
Customer Organization: Florida Dept. of Financial Services, Division of Rehabilitation and Liquidation	Contact Name:	Kathy Bueschel
	Contact Title:	Senior Asset Recovery Analyst
Customer Address: 325 John Knox Road, Atrium Building, Suite 101, Tallahassee, Florida 32303	Contact Phone:	850-413-4512
	Contact Email:	Kathy.Bueschel@myfloridacfo.com
Project Information		
Total Vendor Staff:	**1,900**	
Project Objectives: Subrogation – provide ability to reconcile funds		
Project Description: Deliver monthly reports and funds for clients in receivership		
Vendor's Involvement: Deliver monthly reports and funds for clients in receivership		

Project Benefits: Allows State of Florida to manage receivership successfully				
Key Personnel				
Name: Josh Holmberg		Role: Director, Account Management		
Project Measurements:				
Projected Membership of Vendor's Contract: Equian does not have a direct contract with the State of Florida - 160,000 Lives.		Actual Membership of Vendor's Contract: Equian does not have a direct contract with the State of Florida-approximately160,000 Lives		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	2015	To:	Ongoing
Actual Start and Completion Dates:	From:	2015	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Subrogation - Equian provides end to end payment integrity solutions and operates worldwide.				

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Equian, LLC	Contact Name:	Stephanie Elliot
	Contact Phone:	720-259-4367
Customer Information		
Customer Organization: Aetna Better Health of Illinois	Contact Name:	Robert Tokarz
	Contact Title:	FP & A Senior Consultant
Customer Address: 333 W Walker Drive, Suite 2100, Chicago, IL 60606	Contact Phone:	312-928-3204

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		Contact Email:	Tokarzr1@aetna.com	
Project Information				
Total Vendor Staff:	**1,900**			
Project Objectives: Pre-Payment Review (also known as Itemized Bill Review).				
Project Description: Subrogation - Equian provides end to end payment integrity solutions and operates worldwide.				
Vendor's Involvement: Subrogation - Equian provides end to end payment integrity solutions and operates worldwide.				
Project Benefits: Provides client savings performing end to end payment integrity solutions as well as transparency into reporting results.				
Key Personnel				
Name: Jennifer Skripka		Role: Director, Account Management		
Project Measurements:				
Projected Membership of Vendor's Contract: January 2020 – 7400		Actual Membership of Vendor's Contract: Projected Membership of Vendor's Contract: January 2020 – 7400		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	2015	To:	Current
Actual Start and Completion Dates:	From:	2015	To:	Current
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Pre-Payment - Equian provides end to end payment integrity solutions and operates worldwide.				

First Choice Services, Inc

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: First Choice Services, Inc.	Contact Name:	Judy Akers
	Contact Phone:	304-400-4802
Customer Information		
Customer Organization: WV Bureau for Public Health	Contact Name:	Jim Kerrigan
	Contact Title:	Director of Tobacco Prevention
Customer Address: 350 Capitol Street-Room 526 Charleston, WV 25301	Contact Phone:	304-356-4219
	Contact Email:	JamesF.Kerrigan@wv.gov
Project Information		
Total Vendor Staff:	**10; 4 tobacco coaches/6 call agents**	
Project Objectives: Operates the West Virginia Tobacco Quitline		
Project Description: Operates the West Virginia Tobacco Quitline		
Vendor's Involvement: Operates the West Virginia Tobacco Quitline		
Project Benefits: Guiding participants through enrollment process to obtain tobacco cessation product. The WV Tobacco Quitline is a complete tobacco cessation quitline. Helpline operators refer callers to a coach, counseling, and nicotine replacement therapy help. FCS answers over 11,000 calls per year from West Virginians seeking assistance through this program.		
Key Personnel		
Name: Lindsy Hatfield	Role: Program Director	
Project Measurements:		
Projected Membership of Vendor's Contract: First Choice is not given that information	Actual Membership of Vendor's Contract: Available to all state residents	

Reason(s) for Change in Membership: First Choice is not given that information				
Estimated Start and Completion Dates:	From:	7/1/2017	To:	On Going
Actual Start and Completion Dates:	From:	7/1/2017	To:	On Going
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: N/A				

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: First Choice Services, Inc.	Contact Name:	Judy Akers
	Contact Phone:	304-400-4802
Customer Information		
Customer Organization: Department of Drug and Alcohol Programs, Pennsylvania Get Help Now	Contact Name:	Gloria Gallagher
	Contact Title:	Public Health Program Assistant Administrator
Customer Address: 2601 North 3rd Street Harrisburg, PA 17110	Contact Phone:	717-736-7437
	Contact Email:	glgllaghe@pa.gov
Project Information		
Total Vendor Staff:	**13 Call Agents**	
Project Objectives: Operates the Pennsylvania Get Help Now		
Project Description: Operates the Pennsylvania Get Help Now		

Vendor's Involvement: Operates the Pennsylvania Get Help Now				
Project Benefits: Connecting participants with drug and alcohol treatment and prevention programs. The PA Get Help Now program is a 24/7 resource and referral center designed to streamline the process of seeking help for substance abuse and behavioral health issues for Pennsylvania residents. FCS answers over 17,000 calls per year from Pennsylvanians seeking assistance through this program.				
Key Personnel				
Name: Monique Sypolt		Role: Program Director		
Project Measurements:				
Projected Membership of Vendor's Contract: First Choice is not given that information		Actual Membership of Vendor's Contract: Available to all state residents		
Reason(s) for Change in Membership: First Choice is not given that information				
Estimated Start and Completion Dates:	From:	11/10/2016	To:	Ongoing
Actual Start and Completion Dates:	From:	11/10/2016	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: N/A				

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: First Choice Services, Inc.	Contact Name:	Judy Akers
	Contact Phone:	304-400-4802
Customer Information		
Customer Organization: Virginia Council on Problem Gambling	Contact Name:	C. E. Hawley
	Contact Title:	President of VACPG

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Customer Address: 730 East Broad Street, Room 3080, Richmond, VA 23298	Contact Phone:	804-827-0921
	Contact Email:	CEHawley@vcu.edu

Project Information	
Total Vendor Staff:	**6**

Project Objectives:

Access to treatment for gambling addiction

Project Description:

Helpline 24/7 for folks dealing with gambling addiction /resources for loved ones and family

Vendor's Involvement:

Operates the helpline for VA Problem Gamblers and loved ones

Project Benefits:

Increased access to treatment, counseling, and education.

The Virginia Problem Gambling Helpline includes a 24/7 helpline and chat and text line, with educational mailings, follow-up calls, and referral to treatment providers. FCHS/FCS answers over 6,000 calls per year from Virginians seeking assistance through this program.

Key Personnel	
Name: Jennifer Davis Walton	Role: Director

Project Measurements:	
Projected Membership of Vendor's Contract: First Choice is not given that information	Actual Membership of Vendor's Contract: Available to all state residents

Reason(s) for Change in Membership:

First Choice is not given that information

Estimated Start and Completion Dates:	From:	7/2015	To:	Ongoing
Actual Start and Completion Dates:	From:	7/2015	To:	Ongoing

Reason(s) for Difference Between Estimated and Actual Dates:

N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: N/A

Health Management Systems, Inc.

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: Health Management Systems, Inc.	Contact Name:	Robert Dickerson
	Contact Phone:	212-857-5270
Customer Information		
Customer Organization: Aetna Better Health of Florida	Contact Name:	Claudia Lamazares
	Contact Title:	Chief Operations Officer
Customer Address: 1340 Concord Terrace, Sunrise, FL 33323	Contact Phone:	954-858-3208
	Contact Email:	LamazaresC@aetna.com
Project Information		
Total Vendor Staff:	**Approximately 100 employees providing the services specified below.**	
Project Objectives: Cost avoidance member eligibility verifications (CAV), Medicaid reclamation billing services to appropriate insurers (Direct Bill)		
Project Description: Cost avoidance services (CAV) - proactive notification of other insurance coverage for active Aetna Medicaid members. Medicaid reclamation billing services (Direct Bill) - reclamation billing to a third-party carrier for funds to be issued back to Aetna Medicaid.		
Vendor's Involvement: HMS provides prospective savings to Aetna Better Health of FL by proactively identifying valid other health insurance coverage that overlaps with Medicaid coverage. HMS also performs Medicaid Third Part Liability (TPL) overpayment recovery functions for Aetna Better Health of FL by billing and recovering on improper payments previously made.		
Project Benefits: Ensuring the MCO has the most updated membership coverage information available to ensure the correct billing flows and to recover inaccurate payments made by Medicaid when other coverage exists. Aetna Better Health of Florida's 2019 recoveries from HMS' Direct Bill services (Medicaid reclamation billing): $1,080,728 Aetna Better Health of Florida's 2019 savings from HMS' Cost Avoidance service (other insurance coverage identification): $1,324,619		

Key Personnel	
Name: Douglas Williams	Role: COO
Name:	Role:

Project Measurements:	
Projected Membership of Vendor's Contract: 50,000 - 75,000 members	Actual Membership of Vendor's Contract: 50,505 members (as of 2019)
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	1/1/2017	To:	None
Actual Start and Completion Dates:	From:	1/1/2017	To:	Ongoing

Reason(s) for Difference Between Estimated and Actual Dates:

N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

Ensuring the MCO has the most updated membership coverage information available to ensure the correct billing flows and to recover inaccurate payments made by Medicaid when other coverage exists.

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Health Management Systems, Inc.	Contact Name:	Robert Dickerson
	Contact Phone:	212-857-5270
Customer Information		
Customer Organization: Aetna Better Health of Pennsylvania	Contact Name:	Jason Rottman
	Contact Title:	Chief Executive Officer
Customer Address: 2000 Market Street Philadelphia, PA 1910	Contact Phone:	215-282-3503

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Department for Health and Human Resources
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	Contact Email:	jason.rottman@aetna.com

Project Information

Total Vendor Staff:	Approximately 100 employees providing the services specified below.

Project Objectives: Cost avoidance member eligibility verifications (CAV), Medicaid reclamation billing services to appropriate insurers (Direct Bill)

Project Description: Cost avoidance services (CAV) - proactive notification of other insurance coverage for active Aetna Medicaid members. Medicaid reclamation billing services (Direct Bill) - reclamation billing to a third-party carrier for funds to be issued back to Aetna's Medicaid organization.

Vendor's Involvement: HMS provides prospective savings to Aetna Better Health of PA by proactively identifying valid other health insurance coverage that overlaps with Medicaid coverage. HMS also performs Medicaid Third Part Liability (TPL) overpayment recovery functions for Aetna Better Health of Pennsylvania by billing and recovering on improper payments previously made.

Project Benefits: Ensuring the MCO has the most updated membership coverage information available to ensure the correct billing flows and to recover inaccurate payments made by Medicaid when other coverage exists.

Aetna Better Health of Pennsylvania's 2019 recoveries from HMS' Direct Bill services (Medicaid reclamation billing): $3,324,757

Aetna Better Health of Pennsylvania's 2019 savings from HMS' Cost Avoidance services (other insurance coverage identification): $30,016,350

Key Personnel

Name: Douglas Williams	Role: COO

Project Measurements:

Projected Membership of Vendor's Contract: 100,000 - 140,000 members	Actual Membership of Vendor's Contract: 110,361 members (as of 2019)

Reason(s) for Change in Membership:

None

Estimated Start and Completion Dates:	From:	1/1/2011	To:	None
Actual Start and Completion Dates:	From:	1/1/2011	To:	Ongoing

Reason(s) for Difference Between Estimated and Actual Dates:

N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

Ensuring the MCO has the most updated membership coverage information available to ensure the correct billing flows and to recover inaccurate payments made by Medicaid when other coverage exists.

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Health Management Systems, Inc.	Contact Name:	Robert Dickerson
	Contact Phone:	212-857-5270
Customer Information		
Customer Organization: Aetna Better Health of Virginia	Contact Name:	Jerry Mammano
	Contact Title:	Chief Executive Officer
Customer Address: 9881 Mayland Drive, Richmond VA, 23233	Contact Phone:	609-282-7957
	Contact Email:	MammanoJ@aetna.com
Project Information		
Total Vendor Staff:	**Approximately 100 employees providing the services specified below.**	
Project Objectives: Cost avoidance member eligibility verifications (CAV), Medicaid reclamation billing services to appropriate insurers (Direct Bill)		
Project Description: Cost avoidance services (CAV) - proactive notification of other insurance coverage for active Aetna Medicaid members. Medicaid reclamation billing services (Direct Bill) - reclamation billing to a third-party carrier for funds to be issued back to the Aetna Medicaid organization.		
Vendor's Involvement: HMS provides prospective savings to Aetna Better Health of Virginia by proactively identifying valid other health insurance coverage that overlaps with Medicaid coverage. HMS also performs Medicaid Third Part Liability (TPL) overpayment recovery functions for Aetna Better Health of Virginia by billing and recovering on improper payments previously made.		
Project Benefits: Ensuring the MCO has the most updated membership coverage information available to ensure the correct billing flows and to recover inaccurate payments made by Medicaid when other coverage exists. Aetna Better Health of Virginia's 2019 recoveries from HMS' Direct Bill services (Medicaid reclamation billing): $3,160,038		

Aetna Better Health of Virginia's 2019 savings from HMS' Cost Avoidance services (other insurance coverage identification): $26,041,500				
Key Personnel				
Name: Douglas Williams		Role: COO		
Project Measurements:				
Projected Membership of Vendor's Contract: 50,000 - 100,000 members		Actual Membership of Vendor's Contract: 66,631 members (as of 2019)		
Reason(s) for Change in Membership: None				
Estimated Start and Completion Dates:	From:	1/1/2016	To:	None
Actual Start and Completion Dates:	From:	1/1/2016	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Ensuring the MCO has the most updated membership coverage information available to ensure the correct billing flows and to recover inaccurate payments made by Medicaid when other coverage exists.				

Inovalon, Inc.

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: Inovalon	Contact Name:	Anna Stevenson
	Contact Phone:	301-809-4000 ext. 2728
Customer Information		
Customer Organization: Aetna	Contact Name:	Alan Boyett
	Contact Title:	HEDIS Director
Customer Address: 4500 East Cotton Center Blvd, Phoenix, Arizona 85040	Contact Phone:	928-304-4879
	Contact Email:	BoyettA@aetna.com
Project Information		
Total Vendor Staff:	**2 assigned staff**	
Project Objectives: To produce and deliver regulatory, required, quality measurement and reporting, as well as prospective/monthly reporting.		
Project Description: 2 projects: Annual_National_All and Monthly_National_All		
Vendor's Involvement: Inovalon oversees Aetna's projects, addresses client questions, and provides maintenance and project upgrades, as required, in Inovalon's Cloud environment.		
Project Benefits: Inovalon provides industry-leading toolsets, services, and experience that allows Health Care Services Corporation to successfully report annual HEDIS® rates to NCQA, Centers for Medicare & Medicaid Services (CMS), and other state regulatory entities. Under the Inovalon ONE® platform, the health plan also has the capability to generate prospective, twice-monthly, analytical runs in order to identify gaps in care, and to use towards calculation of provider incentives.		
Key Personnel		
Name: Alan Boyett	Role: HEDIS® Director	
Name: James Trout	Role: Manager, Health Care QM, Data and Reporting	

Project Measurements:				
Projected Membership of Vendor's Contract: 4.3 million		Actual Membership of Vendor's Contract: 3,122,938		
Reason(s) for Change in Membership: Members are added/removed to/from the Plan's prospective project, on a monthly basis, which may cause shifts in overall membership counts from one month to the next.				
Estimated Start and Completion Dates:	From:	6/1/2016	To:	8/31/2020 (with a 1-year auto-renewal)
Actual Start and Completion Dates:	From:	6/1/2016	To:	8/31/2020 (with a 1-year auto-renewal)
Reason(s) for Difference Between Estimated and Actual Dates: There is no difference in Estimated and Actual start/completion dates.				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Inovalon, Inc. provides complete administrative and hybrid rate reporting services in support of Aetna's NCQA HEDIS® submission process. As an NCQA-certified vendor for the past 18 years, Inovalon's experienced teams assist Aetna with the key milestones and tasks associated with the HEDIS® reporting requirements, including data transformation and loading, generation of preliminary rates, generation of the CAHPS/Qualified Health Plan (QHP) survey sample frames, sampling of the hybrid measures, calculation of interim and final rates, assisting the Plan with the HEDIS® Compliance Audit, as well as submissions to NCQA, CMS, and other regulatory agencies. In support of Aetna's state regulatory reporting requirements, Inovalon creates and maintains multiple, custom, and state measure catalogs, outside of the standard HEDIS® measure set. Aetna's HEDIS® project(s) are managed in Inovalon's private Cloud environment, under the Client Cloud Access (CCA) implementation type. Under the CCA implementation, Aetna loads and manages their HEDIS® project and is responsible for the plan's overall quality measurement and reporting timeline. While Aetna performs all of the tasks associated with HEDIS® reporting, Inovalon assigns a dedicated team with an experienced product service manager and technical manager to assist and train those Aetna team members who are dedicated to the project. When technical or software issues occur, the CCA implementation provides the quickest time-to-solution as Inovalon can immediately look at the health plan's project, determine what the problem is, and quickly implement a solution. Additionally, the CCA-hosted option requires fewer resources from Aetna, from a technical and software perspective, and offers the health plan more control over the HEDIS® project. In this option, Aetna pushes its data onto Inovalon servers through a secure connection. Inovalon maintains the hardware and software infrastructure, as well as the storage capacity necessary to host the project(s). Lastly, all software upgrades and system back-ups are Inovalon's responsibility.				

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Inovalon, Inc	Contact Name:	Carol Bilardo
	Contact Phone:	301-809-4000 ext. 6104
Customer Information		
Customer Organization: Health Care Services Corporation	Contact Name:	Terri Kitchen
	Contact Title:	Executive Director, Enterprise Quality & Accreditation
Customer Address: 300 E. Randolph St., Chicago, Illinois 60601	Contact Phone:	312-653-7736
	Contact Email:	Terri_Kitchen@bcbsil.com
Project Information		
Total Vendor Staff:	**2 staff assigned to HCSC**	
Project Objectives: To produce and deliver regulatory, required, quality measurement and reporting, as well as prospective/monthly reporting.		
Project Description: 2 separate projects: HEDIS_19 and Monthly_19.		
Vendor's Involvement: Inovalon oversees Health Care Service Corporation's projects, addresses client questions, and provides maintenance and project upgrades, as required, in Inovalon's Cloud environment.		
Project Benefits: Inovalon provides industry-leading toolsets, services and experience that allows Health Care Services Corporation to successfully report annual HEDIS® rates to NCQA, CMS, and other state regulatory entities. Under the Inovalon ONE® platform, the health plan also has the capability to generate prospective, twice-monthly, analytical runs in order to identify gaps in care, and to use towards calculation of provider incentives.		
Key Personnel		
Name: Karol Rouckus	Role: Director Analytics Consulting	
Name: John Trytek	Role: Unit Manager Analytics Reporting	

Project Measurements:				
Projected Membership of Vendor's Contract: 18 million		Actual Membership of Vendor's Contract: 20,665,715		
Reason(s) for Change in Membership: Members are added/removed to/from the plan's prospective project on a monthly basis, which may cause shifts in overall membership counts from one month to the next.				
Estimated Start and Completion Dates:	From:	1/1/2017	To:	12/31/2021 (with a 2-year auto-renewal)
Actual Start and Completion Dates:	From:	1/1/2017	To:	12/31/2021 (with a 2-year auto-renewal)
Reason(s) for Difference Between Estimated and Actual Dates: There is no difference in estimated and actual start/completion dates.				

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

Inovalon, Inc. provides complete administrative and hybrid rate reporting services in support of Health Care Services Corporation's (HCSC) NCQA HEDIS® submission process. As an NCQA-certified vendor for the past 18 years, Inovalon's experienced teams assist HCSC with the key milestones and tasks associated with the HEDIS® reporting requirements, including data transformation and loading, generation of preliminary rates, generation of the CAHPS/QHP survey sample frames, sampling of the hybrid measures, calculation of interim and final rates, assisting the plan with the HEDIS® Compliance Audit, as well as submissions to NCQA, CMS, and other regulatory agencies. In support of HCSC's state regulatory reporting requirements, Inovalon creates and maintains multiple custom and state measure catalogs outside of the standard HEDIS® measure set.

HCSC HEDIS® project(s) are managed in Inovalon's private Cloud environment, under the CCA implementation type. Under the CCA implementation, HCSC loads and manages their HEDIS® project and is responsible for the plan's overall quality measurement and reporting timeline. While HCSC performs all of the tasks associated with HEDIS® reporting, Inovalon assigns a dedicated team with an experienced product service manager and technical manager to assist and train those HCSC team members who are dedicated to the project. When technical or software issues occur, the CCA implementation provides the quickest time-to-solution as Inovalon can immediately look at the health plan's project, determine what the problem is, and quickly implement a solution.

Additionally, the CCA-hosted option requires fewer resources from HCSC, from a technical and software perspective, and offers the health plan more control over the HEDIS® project. In this option, HCSC pushes its data onto Inovalon servers through a secure connection. Inovalon maintains the hardware and software infrastructure, as well as the storage capacity necessary to host the project(s). Lastly, all software upgrades and system back-ups are Inovalon's responsibility.

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Inovalon, Inc.	Contact Name:	Einat Raitses
	Contact Phone:	301-809-4000 ext. 6127
Customer Information		
Customer Organization: WellCare	Contact Name:	Danny Sharpe
	Contact Title:	Director, Quality Data Integrity
Customer Address: 8735 Henderson Road, Tampa, FL 33634	Contact Phone:	813-206-3577
	Contact Email:	Danny.Sharpe@wellcare.com
Project Information		
Total Vendor Staff:	**2 assigned staff**	
Project Objectives: To produce and deliver regulatory, required, quality measurement and reporting, as well as prospective/monthly reporting.		
Project Description: 2 projects: HEDIS19 and Monthly20		
Vendor's Involvement: Inovalon oversees the projects and provides all output directly to the client, addresses client questions, as needed, and provides required maintenance and upgrades to WellCare's project and Cloud environment.		
Project Benefits: Inovalon provides industry-leading toolsets, services, and experience that allows Health Care Services Corporation to successfully report annual HEDIS® rates to NCQA, CMS, and other state regulatory entities. Under the Inovalon ONE® platform, the health plan also has the ability to generate prospective, analytical runs in order to identify gaps in care and to use towards rate trending and benchmarking.		
Key Personnel		
Name: Danny Sharpe	Role: Director, Quality Data Integrity	
Project Measurements:		
Projected Membership of Vendor's Contract: 6 million	Actual Membership of Vendor's Contract: 4,764,741	
Reason(s) for change in membership: Members are added/removed to/from the Plan's prospective project, on a monthly basis, which may cause shifts in overall membership counts from one month to the next.		

Estimated Start and Completion Dates:	From:	8/17/2010	To:	6/30/2020
Actual Start and Completion Dates:	From:	8/17/2010	To:	6/30/2020

Reason(s) for Difference Between Estimated and Actual Dates:

There is no difference in Estimated and Actual start/completion dates.

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

Inovalon, Inc. provides complete administrative and hybrid rate reporting services in support of WellCare's NCQA HEDIS® submission process. As an NCQA-certified vendor for the past 18 years, Inovalon's experienced teams assist WellCare with the key milestones and tasks associated with the HEDIS® reporting requirements, including data transformation and loading, generation of preliminary rates, generation of the CAHPS/QHP survey sample frames, sampling of the hybrid measures, calculation of interim and final rates, assisting the plan with the HEDIS® Compliance Audit, as well as submissions to NCQA, CMS, and other regulatory agencies. In support of WellCare's state regulatory reporting requirements, Inovalon creates and maintains multiple custom and state measure catalogs outside of the standard HEDIS® measure set.

WellCare's HEDIS® project(s) are managed in Inovalon's private Cloud environment, under the Service Bureau implementation type. With this implementation option, the health plan pushes data, from all sources, onto Inovalon servers through a secure connection. Inovalon is in charge of all the tasks associated with HEDIS® reporting, including data loading/transformation, running analytics to produce preliminary rates, generating hybrid sample frames, as well as generating final rates and NCQA and CMS final submission files. Additionally, in the service bureau implementation, WellCare assists Inovalon in reviewing and signing off on tasks such as cross reference files for provider specialty and homegrown/non-standard codes, data load check figure reports, CAHPS sample frames, preliminary HEDIS® rates, HEDIS® hybrid sample frames, final HEDIS® state-specific rates and outputs, IDSS and CMS submissions, and the HEDIS® compliance audit.

Overall, the service bureau option requires the fewest resources from WellCare, placing the burden of the labor and the associated technology tasks on Inovalon. In the service bureau implementation, Inovalon maintains the Cloud environment and is responsible for all software upgrades and system back- ups related to WellCare's projects. This implementation option frees up WellCare staff, who would otherwise be focused on managing the technical aspects of the HEDIS® project and allows the team to focus on other quality initiatives. However, with Inovalon's unparalleled reporting technologies, WellCare has overall control of the project, with real-time access to detailed information, down to the member- and claims-level detail, and insight into the status of deliverables throughout the project lifecycle.

MCMC LLC

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: MCMC LLC	Contact Name:	Darren Rollins
	Contact Phone:	617-849-9277
Customer Information		
Customer Organization: Illinois Dept of Healthcare Family Services	Contact Name:	Theresa Eagleson
	Contact Title:	Director
Customer Address: 102 South Grand Avenue East, Springfield, IL 60601	Contact Phone:	217-524-7478
	Contact Email:	Theresa.Eagleson@illinois.gov
Project Information		
Total Vendor Staff:	**120**	
Project Objectives: Medical Review of appeals to confirm proper determinations for coverage		
Project Description: MCMC provided review of cases upon request to provide an appeal mechanism for plan members. MCMC utilized specialist physicians to review cases referred.		
Vendor's Involvement: Reviews were conducted and the appeal recommendations were communicated to the plan.		
Project Benefits: MCMC assured an independent appeal process to assist in assuring members of their rights to a fair hearing of their appeal.		
Key Personnel		
Name: Paul Gilleece, RN	Role: VP Operations	
Name: Sean Reardon, RN	Role: Director of Health Review Services	
Project Measurements:		
Projected Membership of Vendor's Contract: Approximately 7,700	Actual Membership of Vendor's Contract: Approximately 7,700	
Reason(s) for Change in Membership:		

N/A				
Estimated Start and Completion Dates:	From:	10/2016	To:	2019
Actual Start and Completion Dates:	From:	10/2016	To:	2019
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: The scope of work was in providing external medical review for appeals.				

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: MCMC LLC	Contact Name:	Darren Rollins
	Contact Phone:	617-849-9277
Customer Information		
Customer Organization: Virginia Department of Medical Assistance Services	Contact Name:	Daniel Plain
	Contact Title:	Director, Health Care Services Division
Customer Address: 600 East Broad Street, 11th Floor, Richmond, Virginia 23219	Contact Phone:	804-588-2866
	Contact Email:	Daniel.Plain@dmas.viriginia.gov
Project Information		
Total Vendor Staff:	**120**	
Project Objectives: Medical Review of appeals to confirm proper determinations for coverage		
Project Description: MCMC provided review of cases upon request to provide an appeal mechanism for plan members. MCMC utilized specialist physicians to review cases referred.		
Vendor's Involvement:		

Reviews were conducted and the appeal recommendations were communicated to the plan.				
Project Benefits: MCMC assured an independent appeal process to assist in assuring members of their rights to a fair hearing of their appeal.				
Key Personnel				
Name: Paul Gilleece, RN		Role: VP Operations		
Name: Sean Reardon, RN		Role: Director of Health Review Services		
Project Measurements:				
Projected Membership of Vendor's Contract: Approximately 164,100		Actual Membership of Vendor's Contract: Approximately 164,100		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	4/2018	To:	Present
Actual Start and Completion Dates:	From:	4/2018	To:	Present
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: The scope of work was in providing external medical review for appeals.				

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: MCMC LLC	Contact Name:	Darren Rollins
	Contact Phone:	617-849-9277
Customer Information		
Customer Organization: New Jersey Department of Human Services	Contact Name:	Jennifer Langer Jacobs
	Contact Title:	Assistant Commissioner, Division of Medical Assistance & Health Services

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-588-2600
	Contact Email:	Jennifer.Jacobs@dhs.state.nj.us

Project Information	
Total Vendor Staff:	**120**

Project Objectives:

Medical Review of appeals to confirm proper determinations for coverage

Project Description:

MCMC provided review of cases upon request to provide an appeal mechanism for plan members. MCMC utilized specialist physicians to review cases referred.

Vendor's Involvement:

Reviews were conducted and the appeal recommendations were communicated to the plan.

Project Benefits:

MCMC assured an independent appeal process to assist in assuring members of their rights to a fair hearing of their appeal.

Key Personnel	
Name: Paul Gilleece, RN	Role: VP Operations
Name: Sean Reardon, RN	Role: Director of Health Review Services

Project Measurements:	
Projected Membership of Vendor's Contract: Approximately 65,800	Actual Membership of Vendor's Contract: Approximately 65,800
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	12/2015	To:	Present
Actual Start and Completion Dates:	From:	12/2015	To:	Present

Reason(s) for Difference Between Estimated and Actual Dates: N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

The scope of work was in providing external medical review for appeals.

MedSolutions, Inc (eviCore)

Table 9: Subcontractor References #1

Vendor Information		
Vendor Name: eviCore healthcare	Contact Name:	Patrick Dawson
	Contact Phone:	800-918-8924 ext. 29252
Customer Information		
Customer Organization: YourCare Health Plan	Contact Name:	Malinda Sant
	Contact Title:	Director of Clinical Management
Customer Address: 1120 Pittsford-Victor Road, Pittsford, NY 14534	Contact Phone:	585-453-8524
	Contact Email:	MSant@yourcarehealthplan.com
Project Information		
Total Vendor Staff:	**5,000+ employees**	
Project Objectives: Vendor (eviCore) is to ensure that the service (outlined below) for which the health plan (YourCare) delegates to vendor (eviCore) to manage are medically necessary.		
Project Description: Radiology, Cardiac Implantable Devices, Radiation Oncology, Sleep Management		
Vendor's Involvement: Medical management of delegated services.		
Project Benefits: Reduction of medically unnecessary services will improve health outcomes and control cost.		
Key Personnel		
Name: Jeff Kraft	Role: VP Client Relationship Executive. Overall responsibility for the relationship	
Name: Kristy Over	Role: Director Client Experience. Owns the day to day operations of the programs	
Project Measurements:		
Projected Membership of Vendor's Contract: 54,000	Actual Membership of Vendor's Contract: 54,000	

Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	1997	To:	Present
Actual Start and Completion Dates:	From:	1997	To:	Present
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Utilization Management and Claim Payment Integrity for Radiology, Cardiology, Post-Acute Care, Radiation Oncology, Chiropractic, Physical Therapy and Occupational Therapy services.				

Table 9: Subcontractor References #2

Vendor Information		
Vendor Name: eviCore healthcare	Contact Name:	Patrick Dawson
	Contact Phone:	800-918-8924 ext. 29252
Customer Information		
Customer Organization: Emblem Health	Contact Name:	Rhonda Robinson
	Contact Title:	VP Vendor Management
Customer Address: 55 Water St, New York, New York 10041-0004	Contact Phone:	646-447-7219
	Contact Email:	Rrobinson2@emblemhealth.com
Project Information		
Total Vendor Staff:	**5,000+ employees**	
Project Objectives: Ensure services being requested are medically necessary.		
Project Description: Covering procedures for Radiology, Cardiology, Radiation Oncology, Post-Acute Care, Physical Therapy and Occupational Therapy		

Vendor's Involvement: Utilization Management and Claims Payment Integrity services for the above procedures				
Project Benefits: Reduction in medically unnecessary procedures for the above programs leading to better care and program savings				
Key Personnel				
Name: Cayce Awe		Role: VP Strategic Client Relationship Executive. Overall responsibility for the relationship		
Name: Adam Ackerman		Role: Director Client Services. Owns the day to day operations of the programs		
Project Measurements:				
Projected Membership of Vendor's Contract: 1,200,000		Actual Membership of Vendor's Contract: 1,200,000		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	1997	To:	Present
Actual Start and Completion Dates:	From:	1997	To:	Present
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Utilization Management and Claim Payment Integrity for Radiology, Cardiology, Post-Acute Care, Radiation Oncology, Chiropractic, Physical Therapy and Occupational Therapy services.				

Table 9: Subcontractor References #3

Vendor Information		
Vendor Name: eviCore healthcare	Contact Name:	Patrick Dawson
	Contact Phone:	800-918-8924 ext. 29252
Customer Information		

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Customer Organization: Aetna	Contact Name:	Julie Cassell-Bryant
	Contact Title:	Director, ECR Vendor Management
Customer Address: 151 Farmington Avenue, Hartford, Connecticut 06156	Contact Phone:	434-951-2435
	Contact Email:	JCBryant@aetna.com

Project Information

Total Vendor Staff:	**5,000+ employees**

Project Objectives:

Perform utilization management (UM) reviews and make medical necessity determinations based on evidence-based criteria

Project Description:

eviCore manages Advanced Imaging and Musculoskeletal Pain Management UM services for Aetna. These services are also provided to Aetna Better Health of West Virginia.

Vendor's Involvement:

eviCore handles utilization management for the aforementioned services.

Project Benefits:

Reduction in medically unnecessary procedures for the above programs, leading to better care for Aetna across lines of business, including the contract for Aetna Better Health of West Virginia.

Key Personnel

Name: Patrick Dawson	Role: Senior Account Executive
Name: Katie Meyer	Role: Client Experience Manager

Project Measurements:

Projected Membership of Vendor's Contract: 10 Million	Actual Membership of Vendor's Contract: 10 Million

Reason(s) for Change in Membership:

N/A

Estimated Start and Completion Dates:	From:	January 2007	To:	Present
Actual Start and Completion Dates:	From:	January 2007	To:	Present

Reason(s) for Difference Between Estimated and Actual Dates:

N/A
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: eviCore performs UM reviews for delegated Aetna membership. eviCore manages Radiology, Cardiology, Sleep, Musculoskeletal, and Radiation Therapy services on behalf of Aetna

NantHealth (Eviti)

Table 9: Subcontractor References #1

Vendor Information		
Vendor Name: NantHealth	Contact Name:	Anne Donovan
	Contact Phone:	201-619-7439
Customer Information		
Customer Organization: Maryland Physicians Care	Contact Name:	Mary Leitch, RN, MSN, CCM
	Contact Title:	VP, Medical Management
Customer Address: 1201 Winterson Rd. Linthicum, Maryland 21090	Contact Phone:	410-412-7770
	Contact Email:	MLeitch@mci-mcmi.com
Project Information		
Total Vendor Staff:	**75**	
Project Objectives: Health utilization management, oncology treatment plan review		
Project Description: Prior authorization recommendations of oncology treatment plans. Reviewed against evidence-based standards		
Vendor's Involvement: Review of treatment plans, recommendation to payer		
Project Benefits: Improvement of adherence to evidence-based standards for oncology patients		
Key Personnel		
Name: Anne Donovan	Role: Account Management	
Project Measurements:		
Projected Membership of Vendor's Contract: 210,000	Actual Membership of Vendor's Contract: ~215,000	
Reason(s) for Change in Membership: Health plan covered members may change month-to-month		

Estimated Start and Completion Dates:	From:	7/2013	To:	Present
Actual Start and Completion Dates:	From:	7/2013	To:	Present
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: NantHealth assists with the prior authorization recommendations of oncology treatment plans. Reviewed against evidence-based standards.				

Table 9: Subcontractor References #2

Vendor Information		
Vendor Name: NantHealth	Contact Name:	Anne Donovan
	Contact Phone:	201-619-7439
Customer Information		
Customer Organization: Sanford Health Plan	Contact Name:	Daniel Weiss
	Contact Title:	Senior Director Pharmacy Benefit
Customer Address: 300 Cherapa Place, Suite 201, Sioux Falls, South Dakota 57103	Contact Phone:	605-312-7488
	Contact Email:	Daniel.Weiss@sanfordhealth.org
Project Information		
Total Vendor Staff:	**75**	
Project Objectives: Health utilization management, oncology treatment plan review		
Project Description: Prior authorization recommendations of oncology treatment plans. Reviewed against evidence-based standards		
Vendor's Involvement: Review of treatment plans, recommendation to payer		
Project Benefits:		

Improvement of adherence to evidence-based standards for oncology patients				
Key Personnel				
Name: Anne Donovan		Role: Account Management		
Name: Bill Giff		Role: Implementation project manager		
Project Measurements:				
Projected Membership of Vendor's Contract: 165,000		Actual Membership of Vendor's Contract: ~165,000		
Reason(s) for Change in Membership: Health plan covered members may change month to month				
Estimated Start and Completion Dates:	From:	12/2016	To:	Present
Actual Start and Completion Dates:	From:	12/2016	To:	Present
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: NantHealth assists with the prior authorization recommendations of oncology treatment plans. Reviewed against evidence-based standards.				

Table 9: Subcontractor References #3

Vendor Information		
Vendor Name: NantHealth	Contact Name:	Anne Donovan
	Contact Phone:	201-619-7439
Customer Information		
Customer Organization: CareSource	Contact Name:	Lori Woodson
	Contact Title:	Manager, Specialty Pharmacy
Customer Address: 140 North Jefferson Street, Dayton, Ohio 45402	Contact Phone:	937-531-2639

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			Contact Email:	Lori.Woodson@CareSource.com	
Project Information					
Total Vendor Staff:	**75**				
Project Objectives: Health utilization management, oncology treatment plan review					
Project Description: Prior authorization recommendations of oncology treatment plans. Reviewed against evidence-based standards					
Vendor's Involvement: Review of treatment plans, recommendation to payer					
Project Benefits: Improvement of adherence to evidence-based standards for oncology patients					
Key Personnel					
Name: Anne Donovan		Role: Account Management			
Name: Bill Giff		Role: Implementation project manager			
Project Measurements:					
Projected Membership of Vendor's Contract: 1,800,000		Actual Membership of Vendor's Contract: ~1,800,000			
Reason(s) for Change in Membership: Health plan covered members may change month to month					
Estimated Start and Completion Dates:	From:	6/2019	To:	Ongoing	
Actual Start and Completion Dates:	From:	6/2019	To:	Ongoing	
Reason(s) for Difference Between Estimated and Actual Dates: N/A					
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: NantHealth assists with the prior authorization recommendations of oncology treatment plans. Reviewed against evidence-based standards.					

Prest & Associates, LLC (Prest)

Table 9: Subcontractor References #1

Vendor Information		
Vendor Name: Prest & Associates, LLC	Contact Name:	Judith Shaffer
	Contact Phone:	608-232-9919
Customer Information		
Customer Organization: Sandhills Center	Contact Name:	Dr. Tony Carraway
	Contact Title:	Medical Director
Customer Address: 201 N. Eugene St. Greensboro, NC 27401	Contact Phone:	919-225-6512
	Contact Email:	TonyC@sandhillscenter.org
Project Information		
Total Vendor Staff:	**22 staff; 41 physician/peer reviewers (independent contractors)**	
Project Objectives: Prest performs independent medical necessity review for behavioral health and substance abuse cases in the state of North Carolina.		
Project Description: Prest performs independent medical necessity review for behavioral health and substance abuse cases in the state of North Carolina.		
Vendor's Involvement: Prest provides an advisory opinion to the vendor.		
Project Benefits: We provide consumers with an independent medical necessity opinion as part of their appeal rights.		
Key Personnel		
Name: Judith Shaffer	Role: General Manager	
Name: Barbara center, MD	Role: Medical Director	
Project Measurements:		
Projected Membership of Vendor's Contract: Sandhills Center manages public mental health, intellectual/developmental disabilities, and substance use disorder services for the citizens	Actual Membership of Vendor's Contract: Sandhills Center manages public mental health, intellectual/developmental disabilities, and substance use disorder services for the citizens of Anson,	

of Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond counties in North Carolina.	Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond counties in North Carolina.
Reason(s) for Change in Membership: No change.	

Estimated Start and Completion Dates:	From:	May 22, 2009	To:	Present
Actual Start and Completion Dates:	From:	May 22, 2009	To:	Present

Reason(s) for Difference Between Estimated and Actual Dates:
N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities

Prest performs independent medical necessity review for behavioral health and substance abuse cases. Prest provides an advisory opinion to the vendor. We provide consumers with an independent medical necessity opinion as part of their appeal rights.

Table 9: Subcontractor References #2

Vendor Information		
Vendor Name: Prest & Associates, LLC	Contact Name:	Judith Shaffer
	Contact Phone:	608-232-9919
Customer Information		
Customer Organization: Beacon Health Options	Contact Name:	Marybeth Ackerman, RN
	Contact Title:	Director National Peer Advisor Services
Customer Address: Beacon Health Options 22001 Loudoun County Pkwy Suite E1-2 Ashburn, VA 20147	Contact Phone:	703-390-5920
	Contact Email:	MaryBeth.Ackerman2@ beaconhealthoptions.com
Project Information		
Total Vendor Staff:	22 staff; 41 physician/peer reviewers (independent contractors)	

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Project Objectives: Prest performs independent medical necessity review for behavioral health and substance abuse cases in multiple states.
Project Description: Prest performs independent medical necessity review for behavioral health and substance abuse cases in multiple states.
Vendor's Involvement: Prest provides an advisory opinion to the vendor.
Project Benefits: We provide consumers with an independent medical necessity opinion as part of their appeal rights.

Key Personnel	
Name: Judith Shaffer	Role: General Manager
Name: Barbara Center, MD	Role: Medical Director

Project Measurements:	
Projected Membership of Vendor's Contract: 4,700 employees nationally, serving more than 40 million people	Actual Membership of Vendor's Contract: 4,700 employees nationally, serving more than 40 million people
Reason(s) for Change in Membership: No change.	

Estimated Start and Completion Dates:	From:	March 19, 1999	To:	Still Current
Actual Start and Completion Dates:	From:	March 19, 1999	To:	Still Current

Reason(s) for Difference Between Estimated and Actual Dates: N/A
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Prest performs independent medical necessity review for behavioral health and substance abuse cases in multiple states. Prest provides an advisory opinion to the vendor. We provide consumers with an independent medical necessity opinion as part of their appeal rights.

Table 9: Subcontractor References #3

Vendor Information		
Vendor Name: Prest & Associates, LLC	Contact Name:	Judith Shaffer
	Contact Phone:	608-232-9919
Customer Information		
Customer Organization: Partners BHM	Contact Name:	Dr. Bess Stanton
	Contact Title:	Medical Director
Customer Address: 901 S. New Hope Rd. Gastonia, NC 28054	Contact Phone:	704-884-2598
	Contact Email:	BStanton@partnersbhm.org
Project Information		
Total Vendor Staff:	22 staff; 41 physician/peer reviewers (independent contractors)	
Project Objectives: Prest performs independent medical necessity review for behavioral health and substance abuse cases.		
Project Description: Prest performs independent medical necessity review for behavioral health and substance abuse cases.		
Vendor's Involvement: Prest provides an advisory opinion to the vendor.		
Project Benefits: We provide consumers with an independent medical necessity opinion as part of their appeal rights.		
Key Personnel		
Name: Judith Shaffer	Role: General Manager	
Name: Barbara Center, MD	Role: Medical Director	
Project Measurements:		
Projected Membership of Vendor's Contract: Partners makes sure everyone who lives in Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry, and Yadkin County and is covered by Medicaid or state health insurance or has no insurance at all receives the best possible services for mental health,	Actual Membership of Vendor's Contract: Partners makes sure everyone who lives in Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry, and Yadkin County and is covered by Medicaid or state health insurance or has no insurance at all receives the best possible services for mental health, substance use disorder, and intellectual and developmental disabilities.	

substance use disorder, and intellectual and developmental disabilities.				
Reason(s) for Change in Membership: No change.				
Estimated Start and Completion Dates:	From:	November 1, 2017	To:	December 31, 2019
Actual Start and Completion Dates:	From:	November 1, 2017	To:	December 31, 2019
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Prest performs independent medical necessity review for behavioral health and substance abuse cases. Prest provides an advisory opinion to the vendor. We provide consumers with an independent medical necessity opinion as part of their appeal rights.				

SKYGEN USA

Table 9: Subcontractor References #1

Vendor Information		
Vendor Name: SKYGEN USA	Contact Name:	Mark Dasek
	Contact Phone:	262.946.4537
Customer Information		
Customer Organization: Horizon Blue Cross Blue Shield New Jersey	Contact Name:	Dr. Fred DiOrio, DMD
	Contact Title:	Dental Director
Customer Address: 1427 Wyckoff Road Farmingdale, New Jersey 07727	Contact Phone:	732-256-5485
	Contact Email:	Fred_DiOrio@horizonnjhealth.com
Project Information		
Total Vendor Staff:	**Approximately 600**	
Project Objectives: SKYGEN USA provides administrative dental services for Horizon's Medicaid members.		
Project Description: SKYGEN performs all services necessary to administer the dental benefit to Horizon New Jersey Health, including implementation, network development, provider relations, credentialing, member services, member outreach, intensive care management, quality, utilization management, appeals and grievances, and reporting. In addition to our policies and procedures that proactively ensure members receive appropriate services and treatment, we have built sophisticated reporting and analytics into our dental benefits software system, the Enterprise System. Our system allows us to run reports designed specifically for Medicaid dental programs that monitor utilization and member outcomes. Using this data, we create interventions, outreach initiatives, and educational campaigns as appropriate for Horizon Blue Cross Blue Shield New Jersey.		
Vendor's Involvement: SKYGEN USA has managed Horizon Blue Cross Blue Shield of New Jersey's Medicaid members since 2012, with a focus on holistic program integrity and stewardship. To address Horizon Blue Cross Blue Shield of New Jersey's most immediate needs, we used a combination of data analytics, fee schedule analysis, and geo-access reporting to analyze costs. We are delegated to perform the following activities for the dental program: • Provider recruitment, credentialing, education, and retention • Authorizations		

- Utilization review and management
- Claims processing and provider payment
- Call center services
- Reporting
- Member services
- Quality assurance
- Complaints, grievances, and appeals
- Fraud, waste, and abuse monitoring

Project Benefits:

For Horizon Blue Cross Blue Shield New Jersey, SKYGEN reduced their per member per month costs, resulting in significant saving while achieving over 80 percent provider satisfaction from 2015 to 2017. We also consulted with Horizon Blue Cross Blue Shield New Jersey to improve their providers' performance and helped protect nearly 1 million members by reducing and preventing fraud, waste, and abuse.

Key Personnel	
Name: Mark Dasek	Role: Relationship Manager
Name: Janine Petragnani	Role: Service Manager
Name: Nicole Martins	Role: Account Manager
Name: Lynn Kern	Role: Director of Claims Administration
Name: Marcel Tetzlaff	Role: Vice President, Provider Experience and Dental Benefits Management
Name: Kyle Koltz	Role: Senior VP Third Party Administration Operations

Project Measurements:	
Projected Membership of Vendor's Contract: 847,000	Actual Membership of Vendor's Contract: 847,000

Reason(s) for Change in Membership:

No change in membership

Estimated Start and Completion Dates:	From:	12/1/2012	To:	Present
Actual Start and Completion Dates:	From:	12/1/2012	To:	Present

Reason(s) for Difference Between Estimated and Actual Dates:

No change in dates

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

All services SKYGEN performs on behalf of Horizon Blue Cross Blue Shield of New Jersey are performed as a subcontractor. This includes provider recruitment, credentialing, education, and retention; authorizations; utilization review and management; claims processing and provider payment; call center services; reporting; member services; quality assurance; complaints, grievances, and appeals; and fraud, waste, and abuse monitoring.

Table 9: Subcontractor References #2

Vendor Information		
Vendor Name: SKYGEN USA	Contact Name:	Mark Dasek
	Contact Phone:	262-946-4537
Customer Information		
Customer Organization: United Concordia Dental	Contact Name:	Daniel J. Wright
	Contact Title:	SVP Government Business & CFO
Customer Address: 4401 Deer Path Road, Harrisburg, Pennsylvania 17110	Contact Phone:	717-260-7182
	Contact Email:	Daniel.Wright@highmark.com
Project Information		
Total Vendor Staff:	**Approximately 600**	
Project Objectives: SKYGEN USA provides administrative dental services for United Concordia's Medicaid members.		
Project Description: **SKYGEN is a dental administrative services organization. We perform all services necessary to** administer the dental benefit to United Concordia in Pennsylvania, Ohio, Kentucky, North Carolina, and West Virginia, including implementation, member services, quality, and reporting. In addition to our policies and procedures that proactively ensure members receive appropriate services and treatment, we have built sophisticated reporting and analytics into our dental benefits software system, the Enterprise System. Our system allows us to run reports designed specifically for Medicaid dental programs that monitor utilization and member outcomes.		
Vendor's Involvement: SKYGEN has been the dental administrator managing United Concordia's Medicaid members since 2012, currently totaling nearly 400,000 members. SKYGEN USA performs the following activities for United Concordia: • Authorizations • Claims processing; provider payment		

- Reporting
- Member services
- Quality assurance

Project Benefits:

SKYGEN USA has effectively managed the dental benefit program for United Concordia, creating efficiencies, working to increase provider and member satisfaction, and improving automated claims processing. Project benefits include improving access to care, reducing program overhead, containing benefit costs, and safeguarding patients.

Key Personnel	
Name: Mark Dasek	Role: Client Experience Executive
Name: Janine Petragnani	Role: Service Manager
Name: Cheryl Lighthart	Role: Account Manager
Name: Lynn Kern	Role: Director of Claims Administration
Name: Kyle Koltz	Role: Senior VP Third Party Administration Operations

Project Measurements:	
Projected Membership of Vendor's Contract: 396,000	Actual Membership of Vendor's Contract: 396,000

Reason(s) for Change in Membership:

No change in membership

Estimated Start and Completion Dates:	From:	4/1/2012	To:	Present
Actual Start and Completion Dates:	From:	4/1/2012	To:	Present

Reason(s) for Difference Between Estimated and Actual Dates:

No change in dates

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

All services SKYGEN performs on behalf of United Concordia Dental are performed as a subcontractor. This includes authorizations, claims processing, provider payment, reporting, member services, and quality assurance.

Table 9: Subcontractor References #3

Vendor Information		
Vendor Name: SKYGEN USA	Contact Name:	Mark Dasek
	Contact Phone:	262.946.4537
Customer Information		
Customer Organization: AmeriHealth Caritas Family of Companies	Contact Name:	Dr. Larry Paul
	Contact Title:	Dental Director
Customer Address: 100 Stevens Drive, Philadelphia, Pennsylvania 19113	Contact Phone:	215-937-7303
	Contact Email:	LPaul@amerihealthcaritas.com
Project Information		
Total Vendor Staff:	**Approximately 600**	

Project Objectives:

SKYGEN USA provides administrative dental services for the AmeriHealth Caritas Family of Companies' approximately 1 million Medicaid members.

Project Description:

SKYGEN is a dental administrative services organization. We perform all services necessary to administer the dental benefit to AmeriHealth Caritas in Pennsylvania, Washington D.C., Delaware, and Michigan, including implementation, member services, quality, reporting, and network development.

Vendor's Involvement:

SKYGEN has been the dental administrator managing AmeriHealth Caritas's Medicaid members since 2011.

We perform the following activities for AmeriHealth Caritas:

- Authorizations
- Claims processing; provider payment
- Reporting
- Call center
- Member services
- Quality assurance
- Complaints, grievances, and appeals

Project Benefits:

SKYGEN USA has effectively managed the dental benefit program for AmeriHealth Caritas, creating efficiencies, working to increase provider and member satisfaction, and improving automated claims processing. For example, in one market we have achieved an auto adjudication rate of over 99%. The

average auto adjudication rate for all AmeriHealth markets was greater than 95% in 2019. Project benefits include reduced program overhead, containing benefit costs, safeguarding patients, and improved access to care. As an example, SKYGEN USA contracted with AmeriHealth to build dental networks in several markets. Combined, we contracted with over 2,000 providers on behalf of AmeriHealth. Additionally, in one market we were able to achieve an access to care rate of 65% for Medicaid members in 2019.

Key Personnel	
Name: Mark Dasek	Role: Client Experience Executive
Name: Janine Petragnani	Role: Service Manager
Name: Luke Kaat	Role: Account Manager
Name: Lynn Kern	Role: Director of Claims Administration
Name: Kyle Koltz	Role: Senior VP Third Party Administration Operations

Project Measurements:	
Projected Membership of Vendor's Contract: 1 Million	Actual Membership of Vendor's Contract: 1 Million
Reason(s) for Change in Membership: No change in membership	

Estimated Start and Completion Dates:	From:	6/1/2011	To:	Present
Actual Start and Completion Dates:	From:	6/1/2011	To:	Present

Reason(s) for Difference Between Estimated and Actual Dates: No change in dates

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: All services SKYGEN performs on behalf of AmeriHealth Caritas Family of Companies are performed as a subcontractor. This includes authorizations; claims processing; provider payment; reporting; member services; quality assurance; call center; and complaints, grievances, and appeals.

Symphony Performance Health, Inc.

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Contact Name:	John DiCesare
	Contact Phone:	404-425-3246
Customer Information		
Customer Organization: Aetna	Contact Name:	Patricia Pomeroy
	Contact Title:	Sr. Project Manager, Provider Experience
Customer Address: Corporate Headquarters 151 Farmington Ave, Hartford, Connecticut 06156	Contact Phone:	480-271-8906
	Contact Email:	PomeroyP@aetna.com
Project Information		
Total Vendor Staff:	**5**	
Project Objectives: Conduct surveys to assess member and provider satisfaction		
Project Description: Provider access, provider satisfaction, member satisfaction surveys		
Vendor's Involvement: SPH provides survey administration services		
Project Benefits: • Certification • Process improvement • Better member outcomes		
Key Personnel		
Name: Patricia Pomeroy	Role: Sr. Project Manager, Provider Experience	
Project Measurements:		
Projected Membership of Vendor's Contract: 10,000,000+	Actual Membership of Vendor's Contract: 10,000,000+	
Reason(s) for change in membership: N/A		

Estimated Start & Completion Dates:	From:	01/2010	To:	12/2020
Actual Start & Completion Dates:	From:	01/2010	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: SPH Analytics partners with Aetna to provide provider access, provider satisfaction, and member satisfaction surveys.				

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Contact Name:	John DiCesare
	Contact Phone:	404-425-3246
Customer Information		
Customer Organization: Aetna Better Health of Illinois	Contact Name:	Corey Taliaferro
	Contact Title:	Director, Service Operations
Customer Address: 333 West Wacker Dr, Suite 2200 MC F646, Chicago, Illinois 60606	Contact Phone:	312-821-6503
	Contact Email:	TaliaferroC@aetna.com
Project Information		
Total Vendor Staff:	**5**	
Project Objectives: Conduct surveys to assess member and provider satisfaction		
Project Description: Provider access; provider satisfaction		
Vendor's Involvement: SPH Analytics provides survey administration services		

Project Benefits: • Certification • Process improvement • Better member outcomes				
Key Personnel				
Name: Corey Taliaferro		Role: Director, Service Operations		
Project Measurements:				
Projected Membership of Vendor's Contract: 898,000		Actual Membership of Vendor's Contract: 898,000		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	01/2015	To:	12/2020
Actual Start & Completion Dates:	From:	01/2015	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: SPH Analytics partners with Aetna Better Health of Illinois to provide provider access and provider satisfaction surveys.				

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Contact Name:	John DiCesare
	Contact Phone:	404-425-3246
Customer Information		
Customer Organization: El Paso First Health Plans Inc.	Contact Name:	Sara Landes, CPHQ
	Contact Title:	Healthcare QM Project Manager
Customer Address: 7400 W. Campus Rd, New Albany, Ohio 43054	Contact Phone:	614-933-8048

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	Contact Email:	LandesS1@aetna.com

Project Information	
Total Vendor Staff:	**5**

Project Objectives:
Conduct surveys to assess member and provider satisfaction

Project Description:
Provider access, provider satisfaction

Vendor's Involvement:
SPH provides survey administration services

Project Benefits:
- Certification
- Process improvement
- Better member outcomes

Key Personnel	
Name: Sara Landes, CPHQ	Role: Healthcare QM Project Manager

Project Measurements:	
Projected Membership of Vendor's Contract: 914,000	Actual Membership of Vendor's Contract: 914,000

Reason(s) for change in membership:
N/A

Estimated Start & Completion Dates:	From:	01/2017	To:	12/2020
Actual Start & Completion Dates:	From:	01/2017	To:	Ongoing

Reason(s) for Difference Between Estimated and Actual Dates:
N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:
SPH Analytics partners with El Paso First Health Plans Inc. to provide CAHPS and provider satisfaction surveys.

Vision Service Plan

Table 9: Subcontractor References#1

Subcontractor Information		
Vendor Name: Vision Service Plan (VSP)	Contact Name:	Larry DeAngelis
	Contact Phone:	330-209-0172
Customer Information		
Customer Organization: BlueChoice HealthPlan of South Carolina	Contact Name:	Scott Timmons
	Contact Title:	Sr. Director Provider Networks
Customer Address: I-20 at Alpine Rd, Columbia, South Carolina 29219	Contact Phone:	803-870-8821
	Contact Email:	Scott.Timmons@bluechoicesc.com

Project Information	
Total Vendor Staff:	**2,600 total employees** **VSP will leverage the experience of 10-12 employees to manage this project.**
Project Objectives: VSP's objectives are to provide high quality routine vision care services to members. Through our delivery model, we will be able to provide various reports on the plan's overall performance.	
Project Description: VSP will maintain claims and provider systems to allow our network of providers to obtain coverage information and submit claims to VSP for routine vision services. Plan members will be able to access a VSP provider to receive routine vision care from our network.	
Vendor's Involvement: VSP will provide network support, development (as needed) and credentialing/recredentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and any reporting specified in the agreement.	
Project Benefits: VSP provided highest level of routine vision care to members, captured member health information for reporting to the State for wellness initiatives, streamlined benefit delivery system for ease of the member and provider interactions -VSP currently shares data, which helps in early detection and management of chronic diseases. -VSP sends Eye Exam Reminder letters and has realized a 22% return rate leading to increased access to preventive care.	

-VSP network doctors are often first to detect early signs of chronic conditions. And VSP members with diabetes are 3x more likely to receive regular eye exams than the general population of insured individuals with diabetes. Source – Nationwide IBM Watson Claims Data. VSP utilization data

Key Personnel	
Name: Janessa Clegg	Role: Implementation Lead and ongoing servicing
Name: Natasha Strickner	Role: Product Project Lead

Project Measurements:	
Projected Membership of Vendor's Contract: 125,000	Actual Membership of Vendor's Contract: 125,000
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	7/1/2010	To:	Present
Actual Start and Completion Dates:	From:	7/1/2010	To:	Present

Reason(s) for Difference Between Estimated and Actual Dates: N/A
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: VSP will provide network support, development (as needed) and credentialing/recredentialing activities, claims processing, call center support (both member and provider), activities associated to member health and wellness, and required reporting.

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Vision Service Plan (VSP)	Contact Name:	Larry DeAngelis
	Contact Phone:	330-209-0172
Customer Information		
Customer Organization: NECA-IBEW Family Medical Care Plan	Contact Name:	Jeri Hill
	Contact Title:	Benefits Administrator

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Customer Address: 5837 Highway 41, Ringgold, Georgia 30736	Contact Phone:	706-937-9602 ext. 860
	Contact Email:	j.hill@nifmcp.com

Project Information	
Total Vendor Staff:	2,600 total employees VSP will leverage the experience of 10-12 employees to manage this project.

Project Objectives:

VSP's objectives are to provide high quality routine vision care services to members. Through our delivery model, we will be able to provide various reports on the plan's overall performance.

Project Description:

VSP will maintain claims and provider systems to allow our network of providers to obtain coverage information and submit claims to VSP for routine vision services. Plan members will be able to access a VSP provider to receive routine vision care from our network.

Vendor's Involvement:

VSP will provide network support, development (as needed), and credentialing/recredentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and any reporting specified in the agreement.

Project Benefits:

- Provided highest level of routine vision care to members
- Captured member health information for reporting to the state for wellness initiatives
- Streamlined benefit delivery system for ease of the member and provider interactions
- VSP currently shares data, which helps in early detection and management of chronic diseases.
- VSP sends Eye Exam Reminder letters and has realized a 22% return rate leading to increased access to preventive care.
- VSP network doctors are often first to detect early signs of chronic conditions. And VSP members with diabetes are 3x more likely to receive regular eye exams than the general population of insured individuals with diabetes. Source – Nationwide IBM Watson Claims Data. VSP utilization data

Key Personnel	
Name: Eric Knapp	Role: Implementation Lead and ongoing servicing
Name: Natasha Strickner	Role: Product project Lead

Project Measurements:	
Projected Membership of Vendor's Contract: 26,688	Actual Membership of Vendor's Contract: 25,450

Reason(s) for Change in Membership:

No changes in membership, all the references mentioned are active contracts, where VSP is covering the entire population.

Estimated Start and Completion Dates:	From:	7/1/2008	To:	Present
Actual Start and Completion Dates:	From:	7/1/2008	To:	Present
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: VSP will provide network support, development (as needed) and credentialing/recredentialing activities, claims processing, call center support (both member and provider), activities associated to member health and wellness, and required reporting.				

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Vision Service Plan (VSP)	Contact Name:	Janessa Clegg
	Contact Phone:	916-858-5254
Customer Information		
Customer Organization: Aetna Better Health of Ohio	Contact Name:	Matt Koblens
	Contact Title:	Vendor Manager
Customer Address: 7400 West Campus Rd, New Albany, Ohio 43054	Contact Phone:	614-254-4681
	Contact Email:	KoblensM@aetna.com
Project Information		
Total Vendor Staff:	2,600 VSP Vision Care employees VSP will leverage the experience of 10-12 employees to manage this project.	
Project Objectives: To identify Diabetic members of Aetna Better Health of Ohio and implement several initiatives to improve Diabetic Member experience and service utilization.		
Project Description:		

With national prevalence rates for diabetes and pre-diabetes soaring, VSP is committed to helping reverse these trends and assist our members in managing these conditions and their complications. We are proud to introduce a new program, VSP Healthy Innovations.

VSP Members get great preventive care with VSP. Now, through the new VSP Healthy Innovations Program, with a special focus on diabetes, they will get an integrated approach to managing overall health through a WellVision Exam® provided by a VSP network doctor. The result is healthier employees, increased productivity, and lower healthcare costs.

With 60% of Americans having at least one chronic condition, and 42% have more than one*, the program focuses on member engagement and education as well as on data collection and exchange with clients, health plans, and disease management vendors.

** RAND Corporation Chartbook, 2017*

Here's how VSP helps Aetna Better Health Members with Diabetes:

1. The EyeRemind Program automatically sends a letter to VSP members who have diabetes and have not received their eye exam within 14 months of last exam. Clients can customize the program with additional reminders, like e-mail or future mailings, for members who still need to receive an eye exam.
2. Engaging in new innovations through partnerships with companies that share our mission. This includes testing new technology and approaches to diabetes care with formal pilots to ensure the best experience and outcome for our clients and members.
3. Diabetes Patient Protocol was developed by a nationwide group of VSP Vision Care providers using guidelines established by the American Optometric Association and American Academy of Ophthalmology. It is followed when treating patients with diabetes and pre-diabetes and includes Exam components, VSP's collaboration with the Member's Primary Care Provider, and Patient education regarding their condition.

Vendor's Involvement:

VSP's Healthy Innovations Program is established and lead by VSP as part of our commitment to improving the health and wellness of Aetna Better Health Members.

Integration: VSP integrates with clients' existing vendors by sharing diabetes and other medical data to help employees manage their chronic conditions. When VSP sends a file to a third party, this helps increase enrollment in the clients' existing disease management/wellness programs.

When a third party sends VSP a file, this allows us to include identified diabetic members in our eye exam reminder program and alerts a VSP doctor of the member's condition prior to their visit. This helps their VSP doctor provide more personalized care.

Innovation: Through new innovations and partnerships with companies and network providers that share our vision, we are continually working to find new ways to identify and manage diabetes and pre-diabetes.

Cultivation: VSP is committed to providing our clients resources that emphasize the importance of an annual VSP® WellVision Exam for their employees. Through a WellVision Exam, a VSP network doctor can detect signs of chronic conditions before they become serious.

Project Benefits:

- **2-Way Data Exchange:** Established a 2-way data exchange to identify and communicate Diabetic members or Members with other chronic conditions to and from both Aetna Better Health and Member Primary Care Providers.
- **Targeted Messaging:** In 2019, VSP identified 5,986 Diabetic members who had not received a WellVision Eye Exam within the last 14 months. VSP issued Exam Reminder letters to these members, resulting in the following success metrics: 225 Diabetic Members received an Eye exam within 90 days of letter receipt. 101 Members received an eye exam within 91-180 days of letter receipt. 326 members received an eye exam within 180 days of letter receipt. Within 12 months of establishing our targeted messaging campaign, Aetna Better Health Medicaid program saw a 6% increase in Diabetic Members utilizing Vision exam and services.

Key Personnel	
Name: Janessa Clegg	Role: Implementation Lead and ongoing servicing
Name: Natasha Strickner	Role: Product project Lead
Project Measurements:	
Projected Membership of Vendor's Contract: 40,000	Actual Membership of Vendor's Contract: 40,000
Reason(s) for Change in Membership: No changes in membership; all the references mentioned are active contracts, where VSP is covering the entire population.	

Estimated Start and Completion Dates:	From:	1/1/2012	To:	Present
Actual Start and Completion Dates:	From:	1/1/2012	To:	Present
Reason(s) for Difference Between Estimated and Actual Dates: N/A				

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

VSP will provide network support, development (as needed) and credentialing/recredentialing activities, claims processing, call center support (both member and provider), activities associated to member health and wellness, and required reporting.

Welltok, Inc.

Table 9: Subcontractor References #1

Subcontractor Information		
Vendor Name: Welltok	Contact Name:	Beth Cappucci
	Contact Phone:	617-285-5623
Customer Information		
Customer Organization: Aetna Better Health of New Jersey	Contact Name:	Joe Lopiccolo
	Contact Title:	Director of Quality
Customer Address: 3 Independence Way # 400 Princeton, New Jersey 08540	Contact Phone:	609-282-8213
	Contact Email:	LopiccoloJ@aetna.com
Project Information		
Total Vendor Staff:	Welltok has approximately 430 staff members who support all of our clients.	

Project Objectives:

Health Programs are automated population health and condition support programs developed in collaboration with third-party content partners, including the American Academy of Pediatrics (AAP) and the American Diabetes Association (ADA). Health Programs currently include programs focused on adult and pediatric preventative health ("Txt4health" and "Text4kids"), maternal health ("Text4baby"), diabetes health ("Care4life") and smoking cessation ("Text2quit").

Welltok provides and customizes quality campaign templates for the Health Plan. These templates are pre-built, evidence based, modifiable templates that can be tailored to supplement or integrate with clinical workflows. Campaigns can be deployed to a full population or targeted cohort. Topics include but are not limited to areas such as chronic condition management, appointment reminders, medication adherence, health risk assessments, gap-in-care alerts, benefits and resources, and re-enrollment reminders.

Project Description:

Implementation, delivery, and support of health messaging platform.

Health Programs are automated population health and condition support programs developed in collaboration with third-party content partners, including the American Academy of Pediatrics (AAP) and the American Diabetes Association (ADA). Health Programs currently include programs focused on adult and pediatric preventative health ("Txt4health" and "Text4kids"), maternal health ("Text4baby"), diabetes health ("Care4life") and smoking cessation ("Text2quit").

Vendor's Involvement:

Implementation, delivery, and support of health messaging platform.

Health Programs are automated population health and condition support programs developed in collaboration with third-party content partners, including the American Academy of Pediatrics (AAP) and the American Diabetes Association (ADA). Health Programs currently include programs focused on adult and pediatric preventative health ("Txt4health" and "Text4kids"), maternal health ("Text4baby"), diabetes health ("Care4life") and smoking cessation ("Text2quit").

Project Benefits:

Welltok has messaged 45,477 members and delivered 657,720 messages on behalf of Aetna Better Health of New Jersey related to the following:

- Women's health, prenatal care, and postpartum care
- Pediatric care
- Adult preventative care
- Diabetes management
- Smoking cessation
- Plan benefits, member satisfaction surveys, Medicaid renewal

Key Personnel	
Name: Beth Cappucci	Role: Sales/ Account Relationship Lead
Name: Izumi Miyazaki	Role: Engagement Manager
Name: Diana Zuskov	Role: Market Solutions and Client Delivery Lead
Name: Jessy Ceruto	Role: Content Manager
Name: Ben Barber	Role: Service Delivery Manager
Name: Austin Thompson	Role: Service Delivery Manager

Project Measurements:	
Projected Membership of Vendor's Contract: 20,927	Actual Membership of Vendor's Contract: 45,477
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	Based on plan's readiness	To:	Ongoing
Actual Start and Completion Dates:	From:	6/26/2019	To:	Ongoing

Reason(s) for Difference Between Estimated and Actual Dates:

Delays in state approvals and data transfers.

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

Please see Project Description and Vendor Involvement

Table 9: Subcontractor References #2

Subcontractor Information		
Vendor Name: Welltok	Contact Name:	Beth Cappucci
	Contact Phone:	617-285-5623
Customer Information		
Customer Organization: Aetna Better Health of Ohio	Contact Name:	Sara Landes
	Contact Title:	Director of Quality
Customer Address: 2841 Woodburn Ave Cincinnati, Ohio 45206	Contact Phone:	614-933-8048
	Contact Email:	Landes1@aetna.com
Project Information		
Total Vendor Staff:	Welltok has approximately 430 staff members who support all of our clients.	
Project Objectives: To provide automated, interactive, evidence-based text messaging health programs and quality campaign templates in order to communicate with and engage members to drive health behavior change and condition management.		
Project Description: Health Programs are automated population health and condition support programs developed in collaboration with third-party content partners, including the American Academy of Pediatrics (AAP) and the American Diabetes Association (ADA). Health Programs currently include programs focused on adult preventative health ("Txt4health"), diabetes health ("Care4life") and smoking cessation ("Text2quit"). Leveraging customized evidence-based templates, Welltok also delivers messages covering topics including diabetes management, medication support, screening reminders, benefits and resources, and Emergency room alternatives.		
Vendor's Involvement: Implementation, delivery, and support of health messaging platform. Health Programs are automated population health and condition support programs developed in collaboration with third-party content partners, including the American Academy of Pediatrics (AAP) and the American Diabetes Association (ADA). Health Programs currently include programs focused on adult preventative health ("Txt4health"), diabetes health ("Care4life") and smoking cessation ("Text2quit").		
Project Benefits:		

Welltok messaged 22,882 members and delivered 1,335,965 messages on behalf of Aetna Better Health of Ohio in 2019.				
Key Personnel				
Name: Beth Cappucci	Role: Sales/ Account Relationship Lead			
Name: Izumi Miyazaki	Role: Engagement Manager			
Name: Diana Zuskov	Role: Market Solutions and Client Delivery Lead			
Name: Jessy Ceruto	Role: Content Manager			
Name: Ben Barber	Role: Service Delivery Manager			
Name: Austin Thompson	Role: Service Delivery Manager			
Project Measurements:				
Projected Membership of Vendor's Contract: 10,724	Actual Membership of Vendor's Contract: 22,882			
Reason(s) for Change in Membership: Actual reach rate exceeded initial targets.				
Estimated Start and Completion Dates:	From:	Q4 2018	To:	Ongoing
Actual Start and Completion Dates:	From:	12/11/2018	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Please see Project Description and Vendor Involvement				

Table 9: Subcontractor References #3

Subcontractor Information		
Vendor Name: Welltok	Contact Name:	Beth Cappucci
	Contact Phone:	617-285-5623
Customer Information		
Customer Organization: Aetna Better Health of Louisiana	Contact Name:	Arlene Goldsmith

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	Contact Title:	Director of Quality
Customer Address: 2400 Veterans Memorial Blvd., Suite 200, Kenner, Louisiana 70062	Contact Phone:	504-667-4648
	Contact Email:	GoldsmithA@aetna.com

Project Information	
Total Vendor Staff:	Welltok has approximately 430 staff members who support all of our clients.

Project Objectives:

To provide automated, interactive, evidence-based text messaging health programs and quality campaign templates in order to communicate with and engage members to drive health behavior change and condition management

Project Description:

Health Programs are automated population health and condition support programs developed in collaboration with third-party content partners, including the American Academy of Pediatrics (AAP) and the American Diabetes Association (ADA). Health Programs currently include programs focused on adult preventative health ("Txt4health"), diabetes health ("Care4life") and smoking cessation ("Text2quit").

Leveraging customized evidence-based templates, Welltok also delivers messages covering topics including diabetes management, medication support, screening reminders, benefits and resources, and Emergency room alternatives.

Vendor's Involvement:

Implementation, delivery, and support of health messaging platform.

Health Programs are automated population health and condition support programs developed in collaboration with third-party content partners, including the American Academy of Pediatrics (AAP) and the American Diabetes Association (ADA). Health Programs currently include programs focused on adult preventative health ("Txt4health"), diabetes health ("Care4life") and smoking cessation ("Text2quit").

Project Benefits:

Welltok messaged 102,305 members and delivered 5,841,913 messages on behalf of Aetna Better Health of Louisiana in 2019.

Key Personnel	
Name: Beth Cappucci	Role: Sales/ Account Relationship Lead
Name: Izumi Miyazaki	Role: Engagement Manager
Name: Diana Zuskov	Role: Market Solutions and Client Delivery Lead
Name: Jessy Ceruto	Role: Content Manager
Name: Ben Barber	Role: Service Delivery Manager
Name: Austin Thompson	Role: Service Delivery Manager

Project Measurements:

Projected Membership of Vendor's Contract: 59,615		Actual Membership of Vendor's Contract: (2019) 102,305		
Reason(s) for Change in Membership: Actual reach rate exceeded initial targets.				
Estimated Start and Completion Dates:	From:	Q4 2018	To:	Ongoing
Actual Start and Completion Dates:	From:	12/11/2018	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Please see Project Description and Vendor Involvement				

6. Financial Stability

The Vendor should provide the following components for this section:

6.1 Dun & Bradstreet (D&B) Ratings

The Vendor should provide the industry standard Dun & Bradstreet (D&B) ratings that indicate its financial strength and creditworthiness, assigned to most U.S. and Canadian companies (and some companies of other nationalities) by the U.S. firm D&B. These ratings are based on a company's worth and composite credit appraisal. Additional information is given in credit reports (published by D&B) that contain the company's financial statements and credit payment history.

The Vendor should provide the following D&B measures:

- PAYDEX
- Commercial Credit Score Percentile (Delinquency Predictor)
- Financial Stress Score
- D&B Viability Rating
- Bankruptcy Found
- D&B Rating

Dun & Bradstreet (D&B) Ratings

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia (Aetna)[1] is proud of our more than 23 year history as a West Virginia Mountain Health Trust plan working to deliver needed supports and services in the most integrated, appropriate, and cost-effective way possible. Our excellent quality scores and strong financials demonstrate our commitment to providing exceptional member service while ensuring financial sustainability, which is a key to Medicaid member access to services. Aetna ensures compliance with all financial security obligations by maintaining a high net worth, exceeding solvency requirements, and by providing transparency into lines of credit and provider risk arrangements.

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor, one of its parents, Aetna Inc., and/or any Aetna Inc. subsidiary that has conducted Medicaid/CHIP business or has participated in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of West Virginia to refer to the vendor, and Aetna Inc. to refer to one of Aetna Better Health of West Virginia's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of West Virginia. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

In support of our commitment to full transparency and to ensure the Department has all financial documentation that may be relevant to confirming the fiscal soundness of our business, we have provided the current D&B Ratings Report for Aetna Better Health of West Virginia and its ultimate parent, CVS Health Corporation (CVS Health). Aetna Better Health of West Virginia has a Favorable viability rating of 34CZ and is identified as having a low risk of insolvency. CVS Health has a Favorable viability rating of 15AB and a Fair D&B Rating of 5A3 with low credit risk. The full list of requested D&B Measures for Aetna Better Health of West Virginia and CVS Health are in included **Table 3.6.1-1.**

Table 3.6.1-1: D&B Measures for Aetna Better Health of West Virginia and CVS Health

D&B Measure	Aetna Better Health of West Virginia	CVS Health
PAYDEX	N/A[2]	69
Commercial Credit Score Percentile (Delinquency Predictor)	72	68
Financial Stress Score	51	48
D&B Viability Rating	34CZ	15AB
Bankruptcy Found	None	None
D&B Rating	N/A[3]	5A3

To support and confirm the fiscal soundness of Aetna Better Health of West Virginia further, we have also provided the ratings for Aetna Better Health of West Virginia from AM Best. AM Best is a credit rating agency that focuses on the insurance sector to provide financial documentation and information to support robust and accurate ratings. The current ratings, effective November

[2] As the ultimate parent, CVS Health is the primary debt-issuing entity. Aetna Better Health of West Virginia is not a debt-issuing entity and therefore does not have ratings beyond what is identified in Table 6.1-1.
[3] Please see the D&B Rating for CVS Health Corporation, provided in Table 6.1-1, as there is not a D&B Rating available for Aetna Better Health of West Virginia.

21, 2019, demonstrate an Excellent financial strength rating of A with stable outlook and an Excellent issuer credit rating of 'a' with stable outlook.

In **Appendix D**, we provide the following documents:

- Dun and Bradstreet report for Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia
- Dun and Bradstreet report for CVS Health
- AM Best report for Aetna Better Health of West Virginia

6.2 Financial Capacity

The Vendor should supply evidence of financial stability sufficient to demonstrate reasonable stability and solvency appropriate to the requirements of this procurement. The Vendor should provide their response as part of their bid in accordance with the template below.

Financial Capacity

Aetna has served Medicaid members in West Virginia since 1996 and has maintained financial solvency and stability throughout our tenure in the State. This longstanding history and ongoing financial stability allow us to help ensure our main focus of putting our members first. Should there be a concern at any time regarding net worth, solvency, or surplus requirements, Aetna will continue to receive financial support in the form of capital contributions from its parent company, Aetna Health Holdings, LLC (Aetna Health Holdings), whose ultimate parent is CVS Health, a Fortune 10 company.

The CVS Health Capital Management team routinely assesses the financial position of each subsidiary. This team completes an estimated net worth calculation one month prior to the close of quarterly financials. If capital contributions are required, the team initiates the transfer of funds prior to the close of each quarter. Aetna Health Holdings, the immediate parent of Aetna Better Health of West Virginia, will provide unconditional financial support to Aetna Better Health of West Virginia in the form of capital contributions to meet State solvency and capital

requirements. We have provided the current Capital Support Letter in **Appendix D**, which details the capital support from Aetna Better Health of West Virginia's parent.

Aetna currently maintains a Certificate of Authority (COA) with the West Virginia Office of the Insurance Commissioner (OIC), which confirms good standing with the State and compliance with all financial requirements to maintain the COA with the West Virginia OIC. This documentation is included in **Appendix** E as part of the requirements for Attachment 3, Section 2, Mandatory Qualifications. We have provided the contact information for the West Virginia OIC in **Table 10** as a credit and financial health reference.

Aetna contracts with Aetna Medicaid Administrators LLC (Aetna Medicaid Administrators), an affiliate company, through a Plan Management Services Agreement for administrative services. Because of this, Aetna Medicaid Administrators is a primary creditor of Aetna Better Health of West Virginia, and we have included them as a credit reference in **Table 10.** We have also included Aetna Medicaid Administrator's bank account institute, Bank of America, as credit reference in **Table 10**. CVS Health holds lines of credit for all its subsidiaries, including Aetna Better Health of West Virginia. CVS Health renewed and refinanced its unsecured revolving credit facilities during the second quarter of 2019. The aggregate amount of its credit facilities is $6 billion, as reflected in **Appendix D** CVS Health 10-Q filing for third quarter of 2019.

Please list credit references that can verify the financial standing of your company.

Table 10: Credit References

INSTITUTION	ADDRESS	PHONE NUMBER
West Virginia Office of the Insurance Commissioner	West Virginia Lottery Building 900 Pennsylvania Avenue Charleston, WV 25302	304-558-2100
Charleston Area Medical Center	501 Morris Street Charleston, WV 25301	304-388-7603

Aetna Medicaid Administrators LLC	4500 E Cotton Center Blvd. Phoenix, AZ, 85040	602-659-9223
Bank of America	100 West 33rd Street, New York, NY 10001	888-841-8159

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ATTACHMENT 4: PROJECT ORGANIZATION AND STAFFING APPROACH

Instructions: The Vendor should employ staffing strategies to ensure all requirements and service levels are met to the Department's satisfaction. The evaluation of the Vendor's staffing approach shall be based on the ability of the Vendor to satisfy the requirements stated herein. Therefore, the Vendor should present detailed information regarding the expertise of the proposed staff and an Initial Staffing Plan.

For ease of formatting and evaluation, ***Attachment 4: Project Organization and Staffing Approach*** provides the required outline for the Vendor's response to staffing. The Vendor's response to the following should not exceed 25 pages, excluding organizational charts, the forms provided in this Attachment, and any supplemental documentation requested as part of the submission.

Please refer to ***Appendix 2: Staff Qualifications, Experience, and Responsibilities*** of the RFP for details pertaining to staff qualifications, experience, and responsibilities.

1. Initial Staffing Plan

As part of the Vendor's bid response, the Vendor should provide an Initial Staffing Plan. In addition to the requirements described in ***Attachment 5: Mandatory Requirements*** and ***Appendix 1: Detailed Specifications***, the Vendor's narrative description of its proposed Initial Staffing Plan should include the following:

- A succinct description of the Vendor's proposed project team that should exhibit the Vendor's ability and capability to provide knowledgeable, skilled, and experienced personnel to accomplish the scope of work as described in this RFP.
- A detailed proposal for providing all resources necessary to fulfill the requirements as specified in this RFP. This includes details covering not only key staff, but also support staff.
- An organizational chart showing the corporate structure, lines of responsibility, and authority in the administration of the Vendor's business as a health plan.
- An organizational chart showing:
    - The organizational structure for this project and how it relates to the proposed service area(s), including staffing and functions performed at the local level.
    - As available, the names, titles, and contact information for the key staff positions or functions listed in ***Appendix 2: Staff Qualifications, Experience, and Responsibilities***. If any individuals are to be hired in the future, provide an approximate timeline for appointment.
    - The reporting relationships of each individual listed.
    - The city and state where each position will be located.
    - Identification of subcontractor staff, if applicable.
- An organizational chart showing how subcontractor(s), excluding direct-care providers, will be managed within the Vendor's West Virginia organizational structure, including the primary individuals at the Vendor's organization and at each subcontractor organization responsible for overseeing such subcontract. This information may be included in the West Virginia organizational chart listed previously or as a separate organizational chart(s).

- A brief narrative explaining the submitted organizational charts, and highlighting the key functional responsibilities and reporting requirements of each organizational unit relating to the Vendor's proposed management of the Vendor program(s).
- A narrative describing tools and processes used to screen available staff to fill positions.
- A narrative describing the process for replacing key staff within defined timeframes, and procedures for backfilling key staff during any transition.
- A hiring plan for administration of the contract awarded through this solicitation.
- Information on how Vendor staffing numbers will reflect adequate access to service populations indicated in this solicitation.
- Information on any additional training or materials—including, but not limited to, the content, methods, and timeframe to initiate and complete training—the Vendor will provide to the Contract Liaison/MHT Administrator to support enrollment.
- Subcontractor Monitoring Plan
    - If the Vendor retains a subcontractor for claims processing, dental benefit management (DBM), behavioral health management, utilization management, or network development, describe activities and monitoring tools for each subcontractor.
    - Provide sample subcontractor agreements for review. The successful Vendors will submit finalized agreements to the Department for approval prior to implementation.
    - If contracting with a benefits manager, provide a separate listing/table of benefit manager vs. Vendor functions in administering the benefits (e.g., provider recruitment, member and provider calls, utilization management, provider education).
    - Identify types of reports/data the subcontractor will provide to the Vendor to help manage medical benefits or other benefits. Indicate the overall content of reports and the frequency with which they will be provided to the Vendor. Please provide sample reports where available.
    - Provide a description of how the Vendor will use reports/data from each subcontractor to ensure appropriate vendor oversight and member access/satisfaction/continuity of care.
    - Identify the frequency of contact/status calls with each subcontractor upon go-live and on an ongoing basis.
    - Describe a plan that will be followed if a subcontractor does not fulfill its contract or service obligations, including, but not limited to, details on any corrective action plan processes.
    - Describe the Vendor's contingency plan if the Vendor or a subcontractor terminates its contract, including plans to identify another subcontractor and transition steps that would take place to ensure uninterrupted member access.
    - Describe whether each subcontractor is an affiliate of the Vendor or an unrelated third party.

As the first managed care organization (MCO) to serve all 55 counties in West Virginia, Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia (Aetna) has been a dedicated partner to the Department for over 23 years. Throughout this partnership with West Virginia Medicaid, we have collaborated on multiple program and benefit expansions and bring proven solutions to ensure the State's vulnerable populations receive the services they need to improve their lives. These efforts are supported by a **staff that is deeply entrenched in the state's culture, with the vast majority being native West Virginians or long-term residents.** Aetna can immediately provide the seasoned staff to support Mountain Health Trust's (MHT) West Virginian Medicaid and West Virginia Children's Health Insurance Program (WVCHIP) through to the next decade. Our staff is ready to quickly update processes and systems to implement new contract requirements with little risk to the Department or disruption to our current enrollees or providers while welcoming new enrollees.

Initial Staffing Plan

Aetna Better Health of West Virginia is staffed to serve the populations for this contract, as we have been supporting our managed care program for over the last 23 years. However, we will hire upon contract award three key staff to staff our team optimally. Our Member Services, Prior Authorization, and Operations functions are all based in our Charleston office. Our Care Management staff is placed throughout the state, which provides a better opportunity for enrollee and provider interaction and understanding of local resources and barriers to care. Our staffing plan is based on the number of projected enrollees and consideration of the special needs of the populations, and it uses a staffing ratio algorithm that includes clinical, non-clinical, and program-wide community-based support workers. Our health plan is authentically West Virginian, rich in experience serving the proposed West Virginia Medicaid populations. **We also**

have extensive experience serving children throughout the state and are prepared to welcome the WVCHIP program with little additional readiness required.

Description of Proposed Project Team Staff Experience and Knowledge

Our proposed project team staff for this new contract has more than 300 combined years of specific, dedicated West Virginia health plan and Medicaid experience. Our staff experience includes working collaboratively with organizations such as schools, Family Resource Network, Mountaineer Food Bank and Facing Hunger Food Bank, Adverse Childhood Experiences Coalition, Healthy Kids, libraries, after-school programs, and the Affordable Healthcare 'Medicaid Matters' group. Our staff members serve on the Perinatal Partnership Substance Use in Pregnancy Committee, supporting child and adolescent behavioral health (BH) and evidence-based practices and interventions, as well as assisting enrollees with a variety of safe, family-oriented events at the Marcum Terrace Family Resource Center. Any key staff changes will be sent to the Department within 14 days. **Table 4.1.1-1** illustrates our staff strengths.

Table 4.1.1-1: Key Staff Knowledge and Experience

Proposed Key Staff	Role	Brief Description: Knowledge and Experience
Greg Carpenter, Master of Arts	Contract Liaison/ MHT Administrator	A native West Virginian with 13 years of health care industry experience and 6 years of managed Medicaid experience in West Virginia, Mr. Carpenter's expertise includes interpersonal communication skills, sales management skills, and organizational and process-improvement skills. He manages the overall direction and day-to-day operations of the entire plan including attending Department meetings and legislative committee hearings; maintaining client relationships and providing timely responses to inquiries; and offering status reports and responses to issues involving health plan functional areas while ensuring enrollees receive care appropriate to their needs, among other duties.
Todd White	Chief Executive Officer	A native West Virginian with 24 years of health care experience, Todd White has developed multiple partnerships with hospital systems, physician practices, and community and state-based agencies, including one of the nation's first neonatal abstinence

Proposed Key Staff	Role	Brief Description: Knowledge and Experience
		syndrome (NAS) facilities, Lily's Place. Employed by Aetna for over 22 years, Mr. White oversees all state contractual requirements and the plan's financial condition and provides direction to and manages more than 172 staff. Under his leadership, Aetna increased its service area from 16 counties in 2006 to all 55 counties in West Virginia by 2012 and achieved the Commendable rating with the National Committee for Quality Assurance (NCQA) with a 4.0 rating.
Tina Bailes	Chief Financial Officer	Tina Bailes' experience includes 16 years working in the Medicaid program, holding various fiscal roles prior to her current role as chief financial officer with Aetna, which she has held for the last 5 years. In her prior role at the state, she served as the deputy commissioner of finance for the West Virginia Bureau for Medicaid Services and was responsible for providing fiscal oversight of the state's (then) $3 billion Medicaid program. Through her state experience, she gained an in-depth understanding of the Medicaid and CHIP programs and the enrollees they serve, the financing structure that supports the programs and the provider landscape.
Alva "Fuzzy" Page III, Esq.	Compliance Officer	Raised in Kanawha County, Mr. Page has extensive health care law experience in government affairs and compliance with 15 years of health care and Medicaid experience and 3 years of managed Medicaid in West Virginia. He is responsible for developing and implementing policies, procedures, and practices, ensuring plan compliance with contract and state and federal requirements. He creates internal controls, policies, and procedures to prevent/detect fraud, waste, and abuse, and he develops our formal Medicaid compliance plan, monitors our Special Investigations unit (SIU) activities, and serves as our primary contact for MHT compliance requests/concerns. Mr. Page also served as the general counsel for the West Virginia Department of Health and Human Resources, Bureau for Medical Services, as assistant attorney general.
Donald Gibbon, Doctor of Osteopathy	Chief Medical Officer/Medical Director	Dr. Donald Gibbon has practiced medicine for 20 years and has 6 years of managed Medicaid experience, 6 years serving as a medical director, and 5 years serving West Virginians. He has worked with enrollees/patients in their recovery from drug and alcohol use for more than 20 years and served as an Open Door Alcohol and Other Drug Treatment Center board member from 1997 to 2006 and past president from 2001 to 2003. His expertise includes leadership roles in emergency, occupational, and urgent care; adult/child trauma treatment; and substance use and trauma; and he has treated children since 1990. Dr.

Proposed Key Staff	Role	Brief Description: Knowledge and Experience
		Gibbon was involved in the collaboration between Aetna and the Bureau of Medicaid Services to develop their opioid management plan.
Frank Angotti III, Doctor of Medicine	Behavioral Health Medical Director	A native West Virginian, Dr. Angotti is an experienced psychiatrist and BH management professional with 10 years of health care experience including over 3 years serving the Medicaid population in West Virginia and over 3 years of managed Medicaid health plan experience. His focus includes leadership roles in child and adolescent psychiatry, behavioral clinic health, and substance use/trauma arenas. He has forged relationships in the West Virginia community as it relates to appropriate therapeutic care for clients and available programs and has extensive experience managing children with complex BH needs under the Medicaid system. Currently, he leads and supports the BH staff, works with upper management to develop the strategic direction of the department, and oversees BH utilization management.
Kimi King, Bachelor of Science in Nursing (BSN), Registered Nurse (RN)	Medical Management Director	Ms. King, a sixth-generation West Virginian, is a clinical services executive with 35 years' health care industry experience and 11 years of managed Medicaid experience in West Virginia. Her expertise includes nursing, clinical management, accreditation preparation, and strategic insights in the medical management arena. As our senior director of health services, Ms. King oversees all areas of medical management for the Medicaid health plan and serves as a member of the Perinatal Partnership Substance Use in Pregnancy Committee. She also works with pregnant women with substance use disorder and babies with NAS and has implemented programs for babies with NAS and high-risk youth.
Johna Easter, RN, Certified Case Manager	Care Management Director	Johna Easter is a certified transplant specialist who has served infants and children needing organ and bone marrow transplants. She is a native West Virginian who grew up in Charleston. Ms. Easter has 36 years of health care experience—26 in managed care and 5 years of managed Medicaid experience in West Virginia. Her expertise includes nursing, clinical case management, and strategic insights in the medical management arena. She oversees staff members, reporting, planning, and developing new care coordination programs. Prior to joining Aetna, Ms. Easter served as the director of care management for HealthSmart Care Management Solutions, where she supervised nurses and performed precertification and case management.

Proposed Key Staff	Role	Brief Description: Knowledge and Experience
Elaina Wickas, RN, BSN	Quality Director	Raised in the Point Pleasant area, Ms. Wickas has 34 years' health care experience and 6 years of managed Medicaid experience in the state, including managed care quality improvement, managing large-scale teams and projects, regulatory and accreditation compliance, and audit oversight. She is responsible for developing/implementing the Quality Assessment and Performance Improvement programs and policies in addition to running the department's operations. She is also an NCQA-certified auditor.
To be hired upon contract award	Member Services Director	Our West Virginia-based Member Services director will have at least three years' experience working with the public in an educational capacity on health insurance-related matters, call center experience, and a bachelor's degree or higher. This key staff member will oversee call center and enrollment/disenrollment activities, grievances, and other enrollee-related inquiries and will assist enrollees in obtaining covered services, handle questions and complaints, and ensure performance requirements.
To be hired upon contract award	Claims Payment Director	Our West Virginia-based claims payment director will have at least three years' health insurer claims processing and encounters experience and a bachelor's degree or higher. This key staff member will oversee the physical and BH claims payment- and encounter-related activities to ensure timely, accurate provider claims payment and to monitor claims processing.
Dorsen McConnaughy, Master of Business Administration (MBA)	Network Development Director	Dorsen McConnaughy is an experienced network development executive who has lived in West Virginia for almost 30 years and has 19 years of managed Medicaid experience, including network development, contract negotiation, provider relations, credentialing, provider billing, and process improvement. Currently, he oversees network development and contracting activities for physical and BH services. Prior to joining Aetna, Mr. McConnaughy served as a network contractor at Wexford Health Sources, where he negotiated contracts with hospitals, ancillaries, and physician groups.
Sarah White, MBA	Provider Relations Director	With 17 years' health care experience and 11 years' managed Medicaid experience in the state, Sarah White's expertise includes provider relations, credentialing, provider billing, and process improvement. A native West Virginian, Ms. White oversees day-to-day staff operations, education, service, reimbursement, and network management, and she ensures contractual metrics are met/exceeded. She has also served as a

Proposed Key Staff	Role	Brief Description: Knowledge and Experience
		senior provider relations representative overseeing credentialing and contracting.
Shannon White-Metz, Master of Hospital and Health Administration	Program Integrity Lead	Ms. White-Metz is a West Virginia native with 20 years' health care experience and 3 years' managed Medicaid experience in West Virginia. Her expertise includes health care fraud investigation, strategic and tactical planning, risk analysis and mitigation, and regulatory compliance. In this role, Ms. White-Metz is the primary contact person for all Department program integrity inquiries and leads all compliance and program integrity efforts for the health plan. Prior to joining Aetna, she served as a paralegal for the Leighway Consulting, where she performed legal research, case planning, development, and management.
Brad Liston, Master of Science	Information Technology Director	A native West Virginian, Mr. Liston has 22 years of health care industry experience and 4 years of managed Medicaid experience in West Virginia and he offers a broad understanding of business processes, information technology (IT) capabilities, IT operations and integration. Currently, he is responsible for supporting health plan systems, data, hardware activities, and required reporting. Prior to joining Aetna, he served as a database administrator of management information systems for the State of West Virginia Department of Health and Human Resources, where he was responsible for data loads, backups, validation, and general financial and medical reporting, data integrity, and data security.
To be hired upon contract award	Community Engagement Director	Our West Virginia-based community engagement director will have at least three years' experience working with the public and will understand insurance and the health care environment and will have knowledge of West Virginia and its population needs. This individual will have a bachelor's degree or higher and will be responsible for marketing, public relations, and community engagement activities. He or she will develop and maintain State-approved marketing policies/procedures, develop a written plan, and submit all marketing materials to the Department while ensuring prohibited marketing activities do not occur.
Jessica Feeney, MBA, Master of Education	Encounter Data Integrity Manager	Ms. Feeney is an experienced manager of business information systems and analytics with a comprehensive background in information technology, data analysis, and project management. She has been with our plan since 2012 and has been our encounter data integrity manager (manager of business information systems and analysis) since 2015. Ms. Feeney leads our Six Sigma initiatives to identify the root cause of errors and solutions to reduce errors while improving overall operational efficiencies. Her duties include ensuring timely,

Proposed Key Staff	Role	Brief Description: Knowledge and Experience
		accurate and complete reporting of all encounter data submissions, including oversight of subcontractor data, oversight of resubmissions due to rate changes or claim resubmissions, and overall responsibility for the data integrity of encounter claims.
LaKeisha Barron-Brown	MHT Member Advocate	Our MHT member advocate, Ms. LaKeisha Barron-Brown, a long-time Charleston resident, has more than 17 years' experience offering counseling to a board range of clients, including patients referred by the Pregnancy Connections Program, navigating patients through the assessment, treatment, and management of drug/alcohol use during pregnancy, managing and coordinating various components in the Drug Court program, and working closely with the West Virginia Department of Health and Human Resources. As our member advocate, Ms. Barron-Brown collaborates with the care management director/care coordinators; provides member support related to enrollment, access, and continuity of care issues; and supports members throughout grievance/appeals activities.
Diane Paletta, Doctor of Dental Surgery	Dental Director	Practicing dentistry for over 40 years in West Virginia, Dr. Paletta has 5 years of managed Medicaid experience, and 40 years serving West Virginians. Her expertise includes general dentistry and Medicaid dental programs. She also serves as the West Virginia dental director for SKYGEN USA. She served as a professor of pharmacology and periodontology in the Division of Dental Hygiene at West Virginia University Tech and as clinical advisor for the West Virginia Board of Dentistry. She has served as a Capitol City Give Kids a Smile volunteer and as the chairperson for the West Virginia Donated Dental Services for the Handicapped Council.

Specialized Staff

As we evaluate needs for the MHT and WVCHIP program, we will explore opportunities to integrate in the care coordination model the use of System of Care (SOC) staff. These individuals have extensive experience in the delivery and implementation of tailored services and supports for West Virginians and are professional leaders who demonstrate passionate support through consultation to help enrollees address and overcome systemic barriers. The following includes a brief description of suggested SOC administrators and their roles:

- Recovery and resiliency SOC administrator, who would develop and implement supportive programs and interventions to address mental health, substance use, care delivery, and coordination, including resiliency training, development, and recovery maintenance
- Child SOC administrator, who would build stakeholder relationships for planning and delivering services and community-based supports for members in all regions
- Adult SOC administrator, who would collaborate with the Department and stakeholders to help enrollees with waiver applications, durable medical equipment, and referrals for independent living skills supports

Extended Support Staff

Aetna will hire two additional case manager associates upon contract award to further support the enrollees who will be joining our health plan. Because we are an incumbent already serving Medicaid members, our extended support staff are already in place and serving these new populations. They include care management, customer service, quality, clinical liaison, special needs representation, and network and operations roles, among others. The knowledge and experience for these positions are highlighted in **Table 4.1.1-2.**

Table 4.1.1-2: Extended Support Staff Knowledge and Experience

Support Staff Positions	Brief Description: Knowledge and Experience
Community Development Coordinator	Develops, facilitates, and implements outreach activities, special events/programs, and presentations to support member education/health plan awareness within the Medicaid or Medicare population and will maintain relationships with community contacts and marketing guidelines/compliance with the State's laws and regulations
Supervisor, Customer Service	Provides overall supervision of customer service employees and will be accountable for member/provider satisfaction, retention, and growth by efficiently delivering competitive services
Care Management Associate	Provides comprehensive health care management to facilitate delivery of appropriate quality health care and promotes cost-effective outcomes and improve program/operational efficiency involving clinical issues
Contract Negotiator	Negotiates and executes contracts to maintain and enhance provider networks to meet/exceed accessibility, compliance, and quality goals
Clinical Liaison	Acts as the clinical lead for integrating enrollee care/clinical coordination; leads the development, implementation, and ongoing monitoring of program and quality initiatives; collaborates with state government, key stakeholders, community organizations, advocacy groups, and our CMO/leadership team
Case Management Coordinator	Collaborates and informs the case management process to facilitate proper health care outcomes for members by providing care coordination, support, and education for members through care management tools and resources

Support Staff Positions	Brief Description: Knowledge and Experience
Customer Service Representative	Serves as the face of Aetna and influence members' service experience through customer service inquiries and making sure problems via telephone, Internet, or written correspondence are handled; also engages, consults, and educates enrollees based on their care needs, preferences, and understanding of plans, tools, and resources
Case Manager, RN	Assesses, plans, implements, and coordinates all case management activities and evaluates medical needs for overall enrollee wellness; develops a proactive course of action to enhance short- and long-term outcomes and to enhance enrollees' overall wellness, including providing input for strategies, policies, and programs for network management and clinical coverage policies
Senior Inbound and Outbound Queue Associate	Supports comprehensive coordination of medical services including intake, screening, and referrals; promotes and supports quality effectiveness of health care services; also serves as a training resource, mentor, and subject matter expert
Manager, Clinical Health Services	Performs oversight/management of clinical team processes, including the development of high-performing teams
Special Needs Representative	Serves as a proactive identifier of enrollees with special needs based on referrals from within or outside the health plan; also coordinates access to care and services appropriate to the enrollee's condition or circumstance
Network Contract Specialist	Loads, implements, and maintains standard provider contracts, schedules, and agreements and files to support business contracting initiatives
Health Care Quality Management Consultant	Develops and maintains ongoing implementation of quality management (QM) work plan activities; also improves quality products and services by using measurement and analysis to process, evaluate, and make recommendations to meet QM objectives
Supervisor, Clinical Health Services	Oversees health care management staff, including high-performing teams; works closely with functional area managers to ensure consistency in clinical interventions; and is accountable for meeting the financial, operational, and quality objectives of the unit
Network Operations Consultant	Serves as the subject matter expert to support contracting initiatives and data audits to enhance provider networks while meeting and exceeding accessibility, compliance, quality, and financial goals; is responsible for reviewing, building, and auditing complex contract and network data
Outreach Coordinator, Healthcare Effectiveness Data and Information Set	Facilitates provider and enrollee outreach to ensure enrollee receipt of important clinical services to improve health outcomes; provides support for healthcare effectiveness data and information set (HEDIS) quality initiatives and regulatory/contractual requirements, including outreach to members who are noncompliant in the designated outreach services; supports effective medical record capture for HEDIS medical record review and abstraction of supplemental data

Support Staff Positions	Brief Description: Knowledge and Experience
Analyst	Gathers initial data in support of research on various projects and may generate reports for internal programs; ensures data quality and programs or retrieves simple reports and generate standard reports for the unit; may assist with analysis and research
Network Relations Consultant	Serves as the primary resource for assigned, high-profile providers or groups (e.g., providers, small groups/systems) to establish, oversee, and maintain positive relationships; assisting/responding to complex issues regarding policies and procedures, plan design, contract language, service, claims, or compensation issues
Clinical Solutions Medical Director	Maintains a balance of internal/external activities to support a higher-touch, patient-centric focus; develops, implements, supports, and promotes population health strategies, tactics, policies, and programs to drive the delivery of high-value health care; manages strategies, policies, and programs comprised of care management, utilization management, quality improvement, and network management and clinical coverage protocol
Health Care QM Analyst	Provides data collection and administrative/technical support to the QM staff to support completion of QM department business plans.
Manager, QM	Maintains oversight of quality management functions; consults and works cross-functionally to influence and promote change to deliver quality service to our internal and external customers
Director, Clinical Pharmacy	Develops and promotes strategies and policies that enhance quality of pharmaceutical care in a cost-effective manner
Finance	Assists with internal and external financial reporting obligations, internal control objectives, and financial system design and operation
Complaint and Appeal Analyst	Manages resolution complaint/appeal scenarios for all products, which may contain multiple issues and may require coordination of responses from multiple business units; ensures timely, customer-focused response to complaints/appeals; identifies trends and emerging issues and report and recommends solutions
Inbound and Outbound Queue Associate	Supports comprehensive coordination of medical services including intake, screening, and referrals to medical services programs; promotes/supports quality effectiveness of health care services
Complaint and Appeal Program Manager	Establishes/maintains, in collaboration with other business units, consistent policies and procedures defining administration and resolution of complaints, grievances, and appeals from enrollee and provider legislative, regulatory, and accreditation requirement complaints
Clinical Case Manager, BH	Uses advanced clinical judgment and critical thinking skills to facilitate appropriate member physical health and BH care through assessment and care planning, direct provider coordination/collaboration, and coordination of

Support Staff Positions	Brief Description: Knowledge and Experience
	psychosocial wraparound services to promote effective use of available resources and optimal, cost-effective outcomes

Resources Necessary to Fulfill Program Requirements

Aetna Better Health of West Virginia is staffed with leadership and support staff currently in place to address the needs of our current enrollees and anticipated WVCHIP enrollees joining our health plan. Support staff roles are described in **Table 4.1.1-2**. Our clearly defined staffing plan is continuous, integrated, and scalable and meets the needs of the programs we administer. It also allows us to remain flexible to address staffing needs as they arise. To support this contract, we are committed to attracting additional professional staff with experience serving West Virginia Medicaid and the WVCHIP program population. Our project leadership includes local staff who are experienced with the Medicaid health care delivery system and the State's culture and who meet the West Virginia licensures and certifications required by law and the contract.

Our contract execution team uses a focused, proven protocol to serve our enrollees. In our 23-year history working with the Department, our implementation processes and readiness reviews have passed all state requirements and met all go-live deadlines within required timeframes. Additionally, our national Medicaid organization has never failed a readiness review, and we will tap into this experience to support the readiness review of this new contract.

Our leadership team will oversee the readiness review for this new contract and includes the regional vice president for Aetna, the plan's CEO, CMO/medical director, CFO, and other health plan staff. It also includes departments such as Grievances and Appeals, Medical Management, Member Services, Network, Pharmacy, Program Integrity, Provider Services, Quality, and Compliance, among others. Our national Medicaid organization team will offer support as needed.

Organizational Chart

As illustrated in **Figure 4.1.1-1**, our key staff will be led by Todd White, CEO of Aetna Better Health of West Virginia and will include Greg Carpenter, the contract liaison/MHT administrator. Our integrated, collaborative team will support this new initiative through consultation, incorporating lessons learned from previous implementations and programs managed. This leadership team will oversee and direct the delivery and operations of the program, leveraging our longstanding, positive relationships with providers, community resources, advocacy groups, regulatory agencies, and other State organizations. Our project leadership team will leverage years of West Virginia Medicaid program experience and best practices gained in other states through connections within the organization. Plan leadership is empowered to make rapid-cycle decisions, ensuring timely and responsive action while delivering high-quality care and services. We will provide the Department with a final organizational chart upon contract award notification and by October 1 of each contract year. The organizational chart will include the names, titles, and contact information for all required key staff positions highlighting any changes.

Key Staff and Service Area Organizational Chart

Figure 4.1.1-1 illustrates our functional operating structure and how each of our key staff report up to top-line plan management. All plan functions ultimately report to Todd White, CEO; whereas the contract liaison/MHT administrator, Greg Carpenter, will oversee the day-to-day operations of the contract. He will be responsible for attending meetings and hearings of legislative committees as requested; making contractual, operational, and financial decisions; overseeing provider relations/contracting; ensuring that each enrollee has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee per 42 CFR § 438.208(b)(1), and meeting requirements

stipulated by the Department. He will also oversee information technology, encounters, member services, and subcontractors Cotiviti, eviCore, SKYGEN USA, and VSP Vision Care.

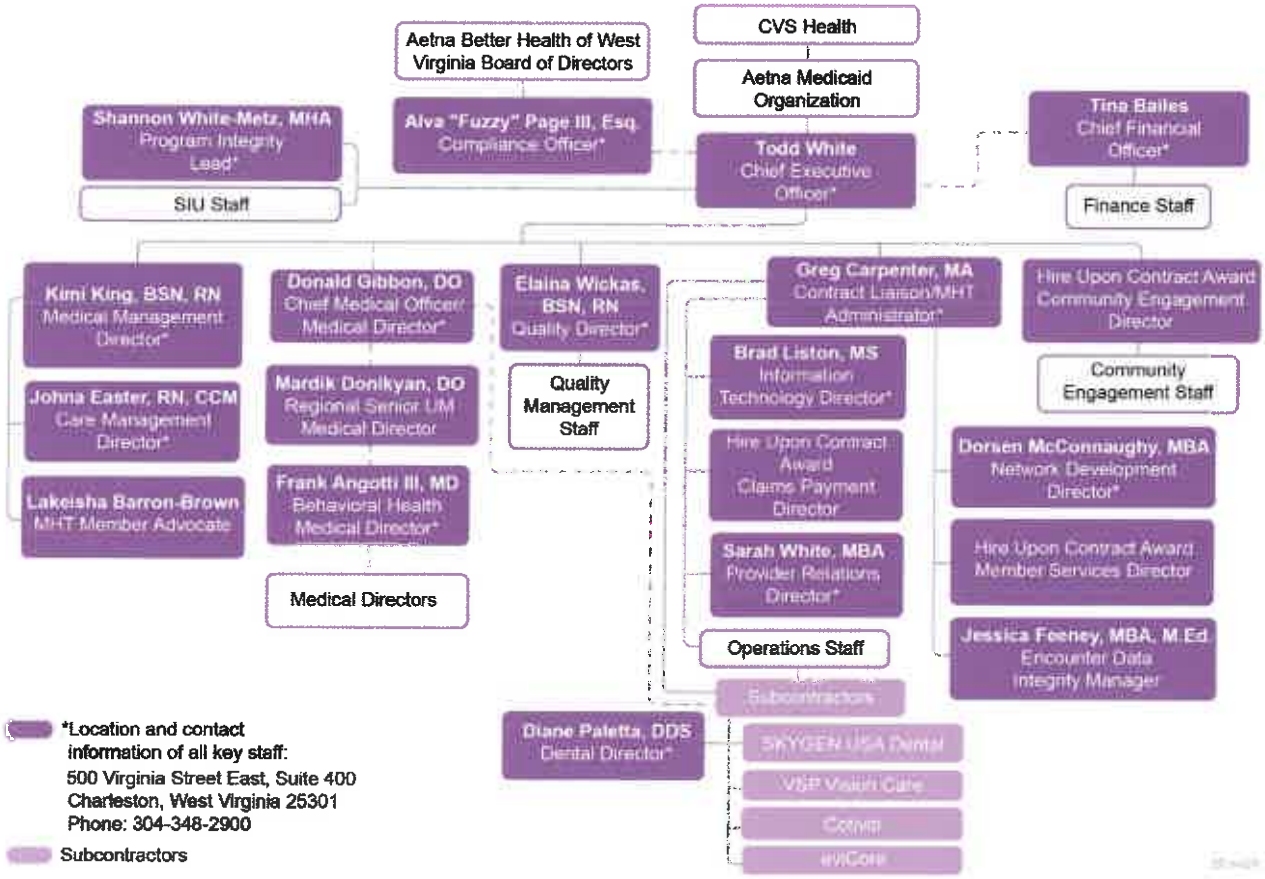


Figure 4.1.1-1: Aetna Key Staff and Proposed Service Areas
Our staff and organizational chart emphasizes experience, accountability, and flexibility.

Organizational Chart Showing Subcontractor Management

Figure 4.1.1-2 illustrates our functional subcontractor structure, which is overseen by our Medical and Operations Management team. We will provide the Department with a final subcontractor organizational chart upon contract award notification. Aetna is dedicated to a cohesive leadership and governance structure to support the West Virginia Medicaid program and the WVCHIP population, providing expert personnel committed to ensuring quality and innovative programming in fulfillment of all contract requirements.



Figure 4.1.1-2: Aetna West Virginia Subcontractor Organizational Chart
Our subcontractor organization chart emphasizes oversight for accountability, compliance, and conscientious stewardship of West Virginia resources.

Figure 4.1.1-2 illustrates ultimate responsibility, key function positions, reporting relationships, and how subcontractors fit into our organization and report up to top-line plan management. Greg Carpenter, our contract liaison/Medicaid administrator will maintain direct operational oversight of subcontracted vendors, including dental and vision, and will be responsible for contractual monitoring activities and reporting. CMO/Medical Director Dr. Donald Gibbon will maintain direct clinical oversight of all our subcontractors and the Joint Oversight Committee (JOC) and Delegated Vendor Oversight Committee (DVOC), which monitor subcontractor performance.

Tools and Processes Used to Screen Available Staff to Fill Positions

As a well-established West Virginia health plan, Aetna uses proven methodologies to maintain staffing. We only hire experienced candidates who meet the qualifications and requirements, and we use screening and hiring tools and techniques that define by position the knowledge, education, skills, and competencies candidates must possess. The hiring process includes the following:

- Using job descriptions to define and communicate properly to candidates the scope of work, job expectations, required knowledge, skills, competencies, and licenses/certifications required, and to assist us further in the targeted evaluation and selection of qualified finalists
- Posting positions specific to experience serving managed care populations and using publications, websites, and other outlets such as organizations that assist those with disabilities and those that support diversity; postings will be available on internal and external job sites, advertising on recruiting websites, job boards, and niche sites
- Launching activities that include virtual job fairs; social sharing of job postings on LinkedIn, leadership networking, resume mining, and web sourcing

- Promoting our internal employee referral program and using employee referral campaigns review of candidate applications by our recruiters
- Prescreening telephonically candidates identified by our recruiters
- Using targeted job-specific interview guides, including behavior-based interview questions and candidate evaluation tools
- Conducting interviews of candidates by our hiring teams and plan leadership; this may include panel interviews and multi-round interviews for select positions
- Vetting key staff finalists with the state and securing state approval for key staff roles
- Offering recruitment incentives to boost candidate interest, such as sign-on bonuses

Our hiring team is comprised of experienced subject matter experts skilled in interviewing and equipped with tools, including competency-focused, behavior-based interview questions, to assess the candidate's ability to perform and their organizational fit. Aetna uses a pre-employment screening when hiring external candidates. Our Human Resources department examines each candidate's job qualifications, including education, experience, and professional references. Candidates are further examined by the supervisors and managers in their individual departments to determine whether they have the proper qualifications, knowledge, and experience. To help ensure enrollee/employee safety, we conduct background screening and criminal background checks on all employees. This process validates that a potential employee is not on the Medicare or Medicaid exclusion list or is liable for or currently facing criminal or civil action for False Claim Act violations; Medicare, Medicaid, consumer, or health care fraud; or similar findings in any jurisdiction. We do not employ or contract with anyone who has been debarred, suspended, or lawfully prohibited from participating in any public procurement/non-procurement activity.

Aetna's national Medicaid organization and its parent company, CVS Health, value a diverse staff and continually work to promote diversity/inclusion at all levels of our health plan, including our hiring and retention practices. We know the value of hiring staff who live in the communities in which they work and who see the effect of what we do with local populations. Our staff

demonstrates its commitment to the communities we serve through developing strong relations with diverse community-based organizations and providing extensive local volunteer services.

Aetna's reputation as an employer of choice enables us to attract the best-qualified candidates, as evidenced by the recognition we have received from a variety of organizations. For example, the United States Business Leadership Network recently recognized the Aetna organization as a best place to work and the American Association of People with Disabilities honored Aetna for our disability-inclusive business practices. Additionally, we were included for the 11th time since 2001 on *DiversityInc's* list of the Top 50 Companies for Diversity. Other examples of our diversity and inclusion include the following:

- Aetna has received a 100 percent rating on the Human Rights Campaign Foundation Corporate Equality Index every year since 2002
- Aetna and CVS both received a 100 percent rating from the American Association of People with Disabilities Disability Equality Index
- National Organization on Disability recognized Aetna with the Leading Disability Employer Seal for exemplary disability hiring and employment practices in 2019
- Aetna has been named to DiversityInc's Top 50 Companies for Diversity for the last 10 years
- National Association of Female Executives (NAFE) ranked Aetna as one of the Top Companies for Executive Women for 20 years, placing Aetna in the NAFE Hall of Fame
- Aetna and CVS were both named to Professional Woman's Magazine's "2019 Best of the Best" Top Employers, Top Supplier Diversity Programs, and Top LGBTQ+ Friendly Companies
- The Hispanic Association of Corporate Responsibility Corporate Inclusion Index recognized Aetna's business practices and corporate strategies
- *Black EOE Journal* named Aetna and CVS to its 2019 Best of the Best lists: Top Employer and Top LGBTQ Friendly Employer
- CVS was also named to the Top Supplier Diversity Program list
- Aetna and CVS were named to the Latina Style Top 50 Companies list for 2018

Process for Replacing Key Staff and Backfilling Positions Within Timeframes

Aetna has a robust talent acquisition and talent succession process designed to ensure smooth delivery of services under the contract. We place a high priority on identifying the best talent from a diverse pool of candidates throughout the state. Once a qualified candidate is hired, the new employee undergoes a structured job orientation. As part of our hiring plan, concurrent with

external sourcing activities, our Talent Acquisition team also identifies internal interim replacement staff who are subject matter experts until permanent replacement staff are hired. In compliance with contract/RFP requirements, Aetna will notify the Department in writing of key staff vacancy or hiring and seek approval of replacement staff.

Hiring Plan for Administration of the Contract Awarded Through This Solicitation

As an incumbent MCO, we are currently staffed and fully operational and as such, we require only minimal staff additions to ensure that there will be no downtime or long implementation. We anticipate a smooth continuum of all program benefits and services and will monitor this by continually reevaluating resources as population and program demands necessitate. Initially, our staffing plan assumes membership of approximately 146,000 for WVCHIP, MHT, and WVHB. It is our practice to hire and train additional staff, refine processes, provide backup resources, and institute other changes to meet the State's requirements if there is an unexpected increase in volume. Successfully calculating our membership's needs is based on data gathered from our Provider Network and Member Services teams and through our community engagement efforts. We work to make sure providers are at the right location within the appropriate timeframe. Key elements of our network strategy include demonstrating compliance with network adequacy and provider accessibility requirements, continuing to enhance our network of high-quality, member-focused providers, offering a comprehensive network to maximize member choice and accessibility, and integrating network development activities with clinical practice models.

Our Member Services team begins enrollee outreach upon enrollment through high-touch, frequent interactions that exceed state requirements for outreach and education. We offer enrollees support through multiple communication methods such as phone calls, letters, and

questionnaires to discover what our enrollees need to receive optimal care and services. Our Community/Stakeholder Engagement team, an in-the-field extension of our Member Services department, interacts with community-based organizations to gain information, resources, and referrals to better serve our enrollees.

How Staffing Numbers Reflect Adequate Access

We anticipate approximately 172 staff members to support this contract. **Table 4.1.1-3** is a breakdown of staff who will support the new contract. We performed a full evaluation in the second quarter of 2019 to confirm whether we needed additional staff and will continue to perform periodic evaluations to maintain optimum staffing ratios. Additionally, we are supported by our national Medicaid organization from functional areas such as Claims, Encounters, and Finance.

Table 4.1.1-3: Functional Departments (FTEs)

Functional Department	FTEs
Leadership and Administration	8
Case Management	62
Community Engagement	4
Compliance	1
Finance	2
Grievance and Appeal	3
Medical Management	4
Member Services	15
Network and Provider Relations	10
Operations	8
Quality	10
Utilization Management	45
Total FTEs supporting the program	172

Our employee training program provides the appropriate orientation, training, and education necessary for all staff to fulfill the requirements of individual positions while adhering to the state's policies and procedures and federal guidelines, laws, and regulations. As new employees join the West Virginia team, they are required to complete onboarding, orientation, and West Virginia-specific and national Medicaid policy training. Ongoing refresher training for employees includes reviews of updated policies, continued competency building, and topics relevant to the West Virginia Medicaid population. Our training approach and knowledge transfer

ensures operational continuity as staff join the team or transition to new roles. New staff members are also linked with more experienced health plan staff for mentorship. In addition to having to pass written, verbal, or case scenario tests, **new employees shadow experienced staff members and are monitored to be sure they meet our standards at 45 to 60 days after training**. They must then submit an attestation confirming training is complete.

Our multimodal West Virginia Medicaid and WVCHIP training includes live instruction, web-based tools, and role playing and will occur throughout the year for new hires and ongoing training is held annually for all incumbent staff. Examples of Aetna's training plan include the following:

- General new hire onboarding followed by functional job training (lasting two to six weeks)
- Trauma-informed care training to achieve the plan's goal of 100 percent trained staff
- Comprehensive overview of our culture, including our values and ethics
- Cultural competency initiatives and training to address enrollees' specific social, behavioral, cultural, language needs and health literacy training
- Training to dispel myths and stigmas related to disabilities and negative attitudes often associated with mental illness and physical/sensorial disabilities
- Examples of mandatory compliance and ethics training include topics such as the Health Insurance Portability and Accountability Act; ethics/code of conduct; compliance; preventing fraud, waste, and abuse (FWA); and diversity
- Job-specific training to include education from experienced personnel in a hands-on environment, access to job-specific policies, procedures, and helpful resources, timeframes to complete assessments, identification of risks/issues, and job shadowing
- Training on technology and systems tools that will support employees in performing their duties and enhance their ability to work efficiently
- West Virginia Medicaid and WVCHIP program-specific assessments and timeframes
- Benefits and coordination of benefits and services

All Aetna employees must complete annual retraining of required policies and procedures:

- Medicare Compliance and FWA Training (Course 210159)
- CVS Health Code of Conduct (Course 209782)
- Recognizing and Preventing Workplace Violence (Course 209725)

Additional Training Materials

Our proposed contract liaison/MHT administrator's duties will be performed by Greg Carpenter.

Mr. Carpenter brings 13 years of health care industry experience and 6 years of managed

Medicaid experience in West Virginia to this position. He is fully qualified to fulfill the position's responsibilities and requires no additional training. However, if the State requires supplementary information for this position, we will confirm with the State the best way to communicate.

Subcontractor Monitoring Plan

Aetna uses qualified, experienced subcontractors only when it adds value for our enrollees. We engage subcontractors for specific deliverables and services relative to improving outcomes for enrollees by providing appropriate, coordinated care and services in a financially responsible manner. Our current subcontractors (VSP Vision Care, eviCore, Cotiviti, Inc., and SKYGEN USA) have an established relationship with our health plan and currently demonstrate sustained quality performance serving our Medicaid enrollees, fulfilling all required quality metrics. Aetna accepts financial, legal, ethical, and all other forms of responsibility for the conduct of all subcontractors and other entities supporting or working on the West Virginia Medicaid/WVCHIP program.

Activities and Monitoring Tools

Prior to contracting with a subcontractor, Aetna evaluates the prospective organization's ability to perform subcontracted activities. Aetna performs a pre-delegation review audit to determine staff qualifications, clinical and administrative capabilities, integration capabilities, data transfer capabilities, operational readiness, and alignment with the project scope of work. Our quality management program includes formal, multilayered processes and comprehensive policies and procedures to monitor contract compliance, quality of care, services, and reporting provided under any subcontract, and all aspects of the contract are evaluated through our Compliance Committee to ensure compliance with contractual requirements. The subcontractors we will use for this contract include VSP Vision Care as our vision provider; SKYGEN USA as our children's dental provider; eviCore as our high-end radiology and pain management subcontractor and for

utilization management (UM) and concurrent reviews; and Cotiviti, Inc. as our retrospective claims processing provider. Local oversight for these providers includes monitoring for VSP Vision Care, SKYGEN USA, eviCore, and Cotiviti through the following tools and processes:

- Monthly: reporting file, provider complaint and appeals file, provider liaison meeting (for VSP), and meeting either in person or telephonically (for all subcontractors); all-MCO meetings (as all the West Virginia health plans that provide Medicaid benefits use SKYGEN USA)
- Quarterly: A DVOC meeting, which may be attended by representatives from all areas of the plan, including the medical director, vendor liaison, CFO, CEO, compliance officer, quality representative, provider relations manager, member services manager, and the vendor's representative, where minutes are reviewed, issues are discussed, and resolutions are tracked; a JOC meeting that may be attended by representatives from all areas of the plan, including the medical director, vendor liaison, CFO, CEO, compliance officer, Quality representative, Provider Relations manager, Member Services manager, and the vendor's representative
- As needed: Field representative/provider meetings to support providers with issues/concerns/education; SIU meeting when there is a possible fraud issue
- Annually: a health plan provider forum activity, which is attended by the SKYGEN representative (for SKYGEN USA)

Oversight also includes a national, local, and financial focus, detailed in the following narrative:

- National oversight: We have a centralized team of delegation oversight experts that manage the process across Aetna's national Medicaid organization's lines of business to ensure all delegated agreements are represented and that all requirements, such as state- and contract-required elements for each plan and delegate, are accounted for. This team includes staff from our national Delegation Management, Quality Management, and Finance departments. Appropriate national Medical Management, Credentialing, Grievance and Appeals, and other teams conduct audits as directed by the Medicaid-specific Quality Management department. The Audit team reports audit findings to Aetna's National Vendor Delegation Oversight Committee (DOC), National Medicaid DOC, and the local health plan DOC to identify opportunities for improvement and solutions that are disseminated across our health plans.
- Financial oversight: Aetna maintains financial oversight by assessing each material subcontractor's financial condition to determine their ability to maintain financial solvency. This due diligence includes a financial review of all delegated entities at least annually to provide oversight of the contractor's continuing compliance to meet Aetna standards. Our Finance team reviews audited and unaudited financial statements and provides an assessment of the results of operation, liquidity of current assets, and sufficiency of cash to pay claims payable and financial reserves. This detailed review helps us determine the risk to Aetna and provides a basis for calculating a letter of credit or insolvency reserve. The Finance team will make recommendations regarding increasing the frequency of additional reviews and will distribute a report to the various oversight committees.
- Annual risk assessment: Aetna will present an annual risk assessment to the State. In turn, we require each of our subcontractors to submit an annual risk assessment to us. Each

subcontractor will conduct an annual risk assessment of their FWA and program integrity procedures. Subcontractors to whom we delegate claims adjudication activities on our behalf will be subject to the same standards as Aetna's claims adjudication. This includes our vision, dental, transportation, and pharmacy subcontractors. All subcontractors' assessments will include a listing of their top five vulnerable areas for that year, plus an action plan of how they will mitigate those risks. We require the risk assessment be submitted within 30 days of its completion each year.

Sample Subcontract Agreements

Attached as **Appendix F** are the sample base subcontractor agreements in support of Aetna's Managed Care program and CHIP business in West Virginia. Our subcontractor agreements also include a regulatory compliance addendum (**Appendix F**) to incorporate pertinent requirements of the state contract and state law. The current Addendum, approved by the Department on September 24, 2018, is attached as **Appendix F.** For any new subcontractors, we will provide the Department with the subcontractor agreement within the timeframe required.

Benefits Manager

Amber Rucker, our internal plan-based network relations manager, monitors benefit functions, including provider recruitment, enrollee and provider calls, medical and behavioral services, UM, reporting, provider education, and others for our subcontractors SKYGEN USA, eviCore, VSP Vision Care, and Cotiviti. These four external, non-affiliated subcontractors serve our enrollees through their own contracted network.

Types of Reports/Data Subcontractors Provide

Our subcontractors supply data and metrics needed to track enrollee access and continuity of care and enrollee and provider satisfaction. Reports we receive include the following:

- **VSP Vision Care reports** (monthly): provider complaint and appeals file report tracks enrollee complaints; customer service report tracks calls answered in 30 seconds, total calls received, calls abandoned, and average rate; claims processing turnaround times tracks number of claims processed in 1 – 30, 31 – 45, 46 – 90, and 90+ days; claims not adjudicated and adjudicated; financial, payment, and overall accuracy; complaint summary measures enrollee and provider complaints received; provider appointment survey measures waiting times for emergency/urgent/routine care, office contacted, number completed, providers surveyed, and number of compliant providers; UM, inter-rater reliability, UM authorization

- **SKYGEN USA reports**: Monthly and quarterly: Managed care FWA report provides information on FWA; Monthly: Provider appointment survey measures waiting times for emergency/urgent/routine care, office contacted, number completed, providers surveyed, and number of compliant providers; third-party recovery report; appeals report provides appeals information; complaints report provides complaints from enrollees; provider directory report provides accuracy of directory; payments to providers tracks payments; received claims report provides claims received by Aetna; claims paid interest provides interest paid by Aetna; claims summary report provides a summary of all claims; claims denial report provides claims denied by Aetna; claims aging report tracks claim aging; credentialing term-suspend report providers suspended due to credentialing issues
- **eviCore reports** (monthly): out-of-network report for review measures out-of-network use; metric report shows all the metrics required of eviCore; eviCore issues log review report that tracks issues/resolution; complaint summary provides turnaround time for response to enrollee complaints; provider appointment survey measures waiting times for emergency, urgent, routine care, office contacted, and number completed and providers surveyed and number of compliant providers
- **Cotiviti reports** (monthly): dashboard report findings tracks financial summary reports such as overpayments and recovered payments; claims processing turnaround times reports the number of claims processed in 1 – 30, 31 – 45, 46 – 90, and 90+ days; and claims adjudicated/not adjudicated financial, payment, and overall accuracy; UM report provides UM prior/retro-authorization, compliance, same-/next-day services, and multi-procedures

Using Reports/Data from Each Subcontractor

Aetna has a well-established Quality Assurance and Performance Improvement (QAPI) program to direct organization-wide initiatives for improving the health and well-being of our enrollees. The data and reporting we gather through the previously discussed reports are used by several committees (described in this section) to help ensure our subcontractors maintain member satisfaction, access to care, and continuity of care. These committee members provide their expertise to assess areas for improvement. Committee members review recommendations, make suggestions, monitor status of corrective actions, and assist in prioritizing resources to achieve the Department's goals. Committees that use reporting and data to monitor and improve enrollee satisfaction, access, and care include the following:

- **Quality Management Oversight Committee (QMOC):** Chaired by the CEO with cross-functional representation, provides executive oversight of the QAPI program and makes recommendations to the board of directors about Aetna quality management and performance improvement activities including the annual QAPI program description, QAPI work plan, and

QAPI evaluation; works to make sure the QAPI plan is integrated throughout the organization/departments, delegated organizations, and network providers/practitioners

- **Delegation Committee:** Chaired by the director of quality management with cross-functional representation, advises/makes recommendations to the QMOC about delegated relationships
- **Complaint Committee:** Chaired by the complaint and appeals supervisor and reviews issues of expression of dissatisfaction by enrollees, practitioners, or providers
- **Service Improvement Committee:** Chaired by the CEO/COO with cross-functional representation, advises and makes recommendations to the QMOC and/or Aetna management about customer, enrollee, and practitioner issues
- **Appeal Committee:** Chaired by the complaint and appeals supervisor with cross-functional representation, reviews appeal trends and may render decisions on administrative or benefit-related appeals filed by enrollees or providers
- **Member Advisory Committee:** Chaired by the Member Services manager with cross-functional representation and enrollee representatives, provides feedback to Aetna regarding strategies for improving enrollee care and services, including health education

Frequency of Contact and Status Calls with Subcontractors During Go-live and Ongoing

During go-live/program readiness we interact with subcontractors at least daily, starting as soon as we receive the first 834 file. For new subcontractors, there may be up to four contacts a day for the first five days (this includes holidays and weekends) to resolve issues. Contact decreases to once a day for approximately seven days and then twice a week for approximately two to four weeks and then once a week for about 30 to 60 days post go-live. We do not decrease contact until leadership confirms that there are no issues and or concerns. After go-live, the health plan begins monthly calls to ensure subcontractors are meeting metrics and once that is confirmed, the frequency moves to a quarterly basis. While formalized reporting occurs quarterly, our provider relations staff maintains frequent contact with key subcontractor staff to ensure collaboration and information-sharing. For example, our Provider Relations staff often contact SKYGEN USA once a week or more depending on ongoing activities.

Plan for a Subcontractor that Does Not fulfill the Contractor or Service Obligations

If we identify a potential deficiency, we work with the subcontractor to ensure compliance to the contract, which includes working with them on customer service techniques, assisting providers, and fulfilling contract service requirements. If noncompliance or risks are identified, we take

immediate action and begin remediation that may include training, more frequent monitoring, corrective action plans (CAPs), sanctions, notices to cure, or subcontractor termination. We implement a CAP to help the subcontractor become compliant and require improvement and resolution on a short timeline, typically 30 or 60 days. Unresolved CAPs may lead to contract termination. Subcontractors are required to follow Aetna's quality improvement process and to report progress quarterly at our JOC meetings. On a quarterly basis, subcontractors report metrics, claims turnaround time, and accuracy. Reports are provided to our various quality management committees, including the Delegation Oversight Committee and the Quality Management Oversight Committee. If the CAP is not successful and the subcontractor's performance remains poor, we may terminate the contract based upon contractual provisions.

Contingency Plan in the Event of Contract Termination

Our processes include a subcontractor contingency plan to protect our enrollees, the Department, and the health plan. We follow subcontractor agreements in the event one is terminated. For example, our dental provider's agreement would require that organization to give us at least written notice 60 days prior to termination. This allows us time to vet a new subcontractor, maintain care standards, and help ensure continuity of care through secure transfer of enrollee records. Our vendor liaison would work with the Department and both the terming and new subcontractors to create a seamless transition.

Affiliated and Non-affiliated Subcontractors

The following subcontractors are non-affiliated with Aetna: VSP Vision Care, SKYGEN USA, eviCore, and Cotiviti. These subcontractors report directly into our operations function with a dotted line to Dr. Gibbon, our CMO/medical director. We will provide the Department with a final organizational chart upon notification of contract award.

2. Key Staff and Resumes

Key staff consist of the Vendor's senior leadership for Mountain Health Trust Managed Care Procurement project. These resources are responsible for providing leadership, and creating the standards and processes required for the successful implementation, operation, and maintenance of the program. Resumes for key staff named in the Vendor proposal should indicate the role of the staff on the Mountain Health Trust Managed Care Procurement project and demonstrate how each staff member's experience and education will contribute to successful implementation and operations. The Vendor's proposed key staff should be available for an in-person interview upon the Department's request.

To ensure successful operations for this contract, the project should be led by key staff identified in the list below:

- Chief Executive Officer/Chief Operating Officer
- Contract Liaison/MHT Administrator
- Chief Financial Officer
- Compliance Officer
- Medical Director
- Behavioral Health Medical Director
- Medical Management Director
- Care Management Director
- Quality Director
- Program Integrity Lead
- Network Development Director
- Provider Relations Director
- Information Technology Director
- Member Services Director
- Claims Payment Director
- Encounter Data Integrity Manager
- Community Engagement Director
- MHT Member Advocate

- Dental Director

The qualifications, experience, and responsibilities for each key staff role are defined in ***Appendix 2: Staff Qualifications, Experience, and Responsibilities***.

3.1 Resumes

The Vendor should complete Table 11 and embed resumes of all proposed key staff as part of their bid. Each resume should demonstrate experience relevant to the position proposed. If applicable, each resume should include work on projects cited under the Vendor's corporate experience, and the specific functions performed on such projects. This section should include the following:

- Resumes (not exceeding two pages each) for key staff and support staff members assigned to this project, including their licenses, credentials, and experience. The Department considers key staff resumes as a key indicator of the Vendor's understanding of the skill sets required for each staffing area. Resumes should be in 12-point font, and double-sided.
- A letter of intent for each proposed staff member not currently employed by the Vendor. Each letter of intent should be signed by the named individual, indicating that the individual is willing to accept employment if the Vendor is awarded the contract.

Aetna Better Health of West Virginia (Aetna[1]) is fully prepared and ready to seamlessly incorporate additional enrollees into our West Virginia Medicaid program and welcome West Virginia Children's Health Insurance Program (WVCHIP) enrollees. For more than two decades, Aetna (previously as Coventry Health Care) has served populations including Temporary Assistance for Needy Families (TANF), children with special health care needs, those receiving supplemental security income, those receiving benefits and services through the Affordable Care Act, and children and pregnant women through our Medicaid and TANF programs. Additionally, we are also just completing our readiness review to begin serving our newest population through the Mountain Health Promise project. Through this combined experience, we

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor, one of its parents, Aetna Inc., and/or any Aetna Inc. subsidiary that has conducted Medicaid/CHIP business or has participated in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of West Virginia to refer to the vendor, and Aetna Inc. to refer to one of Aetna Better Health of West Virginia's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of West Virginia. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

are well-positioned to meet the unique challenges facing West Virginia today, as well as continuing to enhance coordination of care and access to services, including physical health, behavioral health, pediatric dental, and vision care for these populations.

We are West Virginians committed to providing enrollees the benefits, services, and health care solutions that support a higher quality of life. Our staff have proven, local experience delivering this care. These are the individuals who 'make it happen.' They are dedicated, innovative, and provide consistent, quality care through a thoughtful, comprehensive approach that reaches across the entire continuum of care. Additionally, the vast majority of our staff are native West Virginians or long-term residents who are deeply connected to their communities throughout the state and understand their neighbors' needs, as is reflected by our superior staff efforts to win and maintain National Committee for Quality Assurance (NCQA) 'Commendable' status for more than three years.

Through this contract, Aetna will fulfill our mission to provide services, benefits, and supports to help lift all vulnerable individuals to a better, more promising future. Our WVCHIP program will be led by our seasoned key staff and senior leadership, who together offer more than 300 years of local, collective health care experience in areas such as social determinants of health, substance use, high-risk youth, social work, and behavioral health, among others. Our key staff's specific experience with these populations, which is highlighted in the following information, details how we currently and will continue to provide meaningful value to every enrollee.

Each key staff resume highlights the education, knowledge, and expertise specific to the populations and the contract requirements that will support and enhance our West Virginia

Managed Care/WVCHIP programs. Support staff is currently in place to manage this new contract and job descriptions are addressed as part of the Initial Staffing Plan response. Key staff resumes and **Table 4.3.1-1** include experience and relevant project information, as well as educational and any applicable licensure information.

Table 4.3.1-1: Resumes for Proposed Key Staff

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
Todd White	Chief Executive Officer	Todd White, a native West Virginian based in our Charleston office, currently serves as the chief executive officer and is responsible for delivering on all state requirements, such as contractual, operational, and financial decisions for the contract related to business, claims payment, provider relations/contracting, and all other functions of Aetna. Additionally, he provides direction and oversight to more than 160 direct reports. Under his leadership, Aetna increased its service area from 16 counties in 2006 to all 55 counties in West Virginia by 2012. Aetna has also achieved the 'Commendable' rating from the NCQA and is currently the only state managed care organization scored at that level. During his 24 years of health care industry experience, Mr. White has developed multiple partnerships with hospital systems, physician practices, and community- and state-based agencies—including one of the nation's first neonatal abstinence syndrome facilities, Lily's Place. Mr. White has been employed by Coventry Health Care, then after the acquisition, Aetna, for over 22 years. Prior to his experience working at the health plans, Mr. White worked with vulnerable youth at the West Virginia Rehabilitation Center. He is a longtime member of the West Virginia Association of Health Plans and serves as the secretary/treasurer. He earned his Bachelor of Science in Electrical Engineering and Technology from West Virginia Tech in Montgomery.	Yes
Greg Carpenter, MA	Contract Liaison/Mountain Health Trust (MHT) Administrator	Greg Carpenter, a native West Virginian, is an experienced executive who has 13 years of health care industry experience and 6 years of managed Medicaid experience in West Virginia. His expertise includes interpersonal communication skills, sales management skills, and organizational and process improvement skills. In his role as the chief operating officer for Aetna Better Health of West Virginia, Mr. Carpenter	Yes

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		is responsible for overall direction and day-to-day operations of the entire plan. Prior to joining Aetna, he served as the West Virginia director of Medicare sales and service for The Health Plan, where he was responsible for directing and overseeing the activities of the Medicare sales department in the state. Additionally, Mr. Carpenter serves at Cross Lanes Baptist Church and has ministered to children who have experienced hardship. He earned his Master of Arts (MA) in Theology from Liberty Baptist Theological Seminary and Graduate School in Lynchburg, Virginia where he graduated Cum Laude. He also earned a Bachelor of Arts in Business Administration from West Virginia State University.	
Tina Bailes	Chief Financial Officer	Tina Bailes' experience includes 16 years of service working in the state Medicaid program, holding various fiscal roles prior to transitioning to her current role as chief financial officer. Ms. Bailes, a lifelong West Virginian, has been chief financial officer of Aetna since 2014. She is located at the Charleston office and is responsible for oversight of our provider payment arrangements, including alternative payment models (APMs); data certification forms, including all encounter data and financial data, and reporting for payments to contracted providers; and certifying payment information used for rate-setting purposes or any other payment-related data required by the Department. Previously she served as the deputy commissioner of finance for the West Virginia Bureau for Medicaid Services and provided fiscal oversight of the State's (then) $3 billion Medicaid program. Through her experience, she has developed an in-depth understanding of the Medicaid program and the enrollees served through the program, as well as the financing structure for access to needed services and provider participation to ensure services are delivered. Ms. Bailes has a Bachelor of Science in Business Administration from West Virginia State College in Institute.	Yes
Alva "Fuzzy" Page III, Esq.	Compliance Officer	Alva "Fuzzy" Page III, Esq., based in our Charleston office, is an executive with extensive health care law experience and success in government affairs and compliance. He is a West Virginia native with 15 years of health care and Medicaid industry experience and 3 years of managed Medicaid experience in the areas of program integrity and fraud prevention in West Virginia. His expertise includes experience	Yes

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		in Medicaid matters in federal and circuit courts, as well as strategic and tactical planning. Currently, Mr. Page is responsible for developing and implementing policies, procedures, and practices to ensure compliance with all contractual, state, and federal requirements; he also creates policies and other control measures to prevent and detect fraud, waste, and abuse. Additionally, he monitors Special Investigations Unit (SIU) activities and supervises our program integrity lead; he established our policies and procedures to maintain and protect member data and serves as our main contact for all MHT compliance communication, among other duties. Mr. Page has a Doctor of Jurisprudence from Capital University School of Law from Columbus, Ohio, and a Bachelor of Science in Accounting from Salem-Teikyo University in Salem.	
Donald Gibbon, DO	Chief Medical Officer/Medical Director	Donald Gibbon, Doctor of Osteopathy (DO), is an experienced executive who has practiced emergency medicine for more than 20 years. Based out of the Charleston office, he has 6 years of managed Medicaid experience, 6 years serving as a medical director, and 5 years serving West Virginia as well as working with enrollees and patients to support them in their recovery from drug and alcohol use for more than 20 years. His expertise includes leadership roles in the emergency occupational and urgent care medicine fields, adult and child trauma treatment, and substance use disorder arenas. He also served as an Open Door (alcohol and other drug treatment center) board member from 1997 to 2006 and was president from 2001 to 2003. From routine complaints to physical abuse, sexual abuse, suicidal ideation and attempts, trauma, and other behavioral issues, Dr. Gibbon has examined and treated children and adults of all ages. Currently, he is responsible for oversight of our medical and care coordination activities for the health plan. He develops and implements strategies for utilization management, quality improvement, network management, and clinical policies to drive excellence in patient care; leads a team of medical directors and other clinical staff; attends in person, when requested by the Department, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers; participates in the Quality Assurance and Performance Improvement Committee (QAPI); and	Yes

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		responds to requests of the Department's medical director or contract administrator. He holds a Doctor of Osteopathy from Kirksville College of Osteopathic Medicine in Kirksville, Missouri, and a Bachelor of Science in Biology from Mercyhurst College in Erie, Pennsylvania. He has a registered medical license from the West Virginia Board of Medicine (license: 2974).	
Frank Angotti III, MD	Behavioral Health Medical Director	Frank Angotti III, Doctor of Medicine (MD), is an experienced psychiatrist and behavioral health management professional and a native West Virginian residing in Morgantown. Dr. Angotti has 10 years of health care industry experience, including over 3 years serving the Medicaid population in West Virginia and over 3 years of managed Medicaid health plan experience. His expertise includes leadership roles in child and adolescent psychiatry, behavioral clinic health, and substance use/trauma arenas. Dr. Angotti is responsible for oversight of our behavioral health clinical and quality activities and participates in behavioral health service utilization review decisions; he responds to behavioral health clinical issues, utilization review, and behavioral quality of care inquiries. He also attends, in person and when requested by the Department, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers. Dr. Angotti's education includes a Fellowship in Child and Adolescent Psychiatry from the University of North Carolina Hospitals, Department of Psychiatry in Chapel Hill, North Carolina; a General Psychiatry Residency at the University of North Carolina Hospitals, Department of Psychiatry, in Chapel Hill, North Carolina; a Doctor of Medicine from West Virginia University School of Medicine in Morgantown; and a Bachelor of Science in Biology from West Virginia University, Eberly College of Arts and Sciences. He has a registered medical license from the West Virginia Board of Medicine (25460), as well as certifications from the American Board of Psychiatry and Neurology, Child, and Adolescent Psychiatry, and the American Board of Psychiatry and Neurology – Psychiatry.	Yes
Kimi King, BSN, RN	Medical Management Director (Senior	Kimi King, a sixth-generation West Virginian located in our Charleston office, is an experienced clinical services executive. Ms. King has 35 years of health care industry experience and 11 years as a utilization management manager or specialist for a managed Medicaid plan in West	Yes

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
	Director of Health Services)	Virginia. She is based in the Charleston office. Her expertise includes nursing, clinical management, accreditation preparation, and strategic insights in the medical management arena. Ms. King is currently responsible for oversight of our utilization management activities, including utilization management program operations such as oversight and management of processing referrals and pre-authorization requirements, as well as familiarity with appeal procedures. She is also required to respond to requests made by the Department's medical director or contract administrator within three business days. Ms. King has a Bachelor of Science in Nursing (BSN) from Alderson Broaddus University in Philippi and a registered nursing (RN) license from the West Virginia Board of Nursing (license: [redacted]	
Johna Easter, RN, CCM	Care Management Director	Johna Easter, RN, certified case manager (CCM), and native West Virginian, is an experienced care management executive who is in our Charleston office. Ms. Easter has 36 years of health care industry experience and 5 years of managed Medicaid experience in West Virginia. Her expertise includes nursing, clinical case management, and strategic insights in the medical management arena, as well as the ability to communicate in an informed and gentle manner with enrollees who have complex medical needs. Currently, she oversees our care management program operations, including but not limited to management and integration of care through the member's primary care provider, referral processes for medically necessary services, provision of early and periodic screening, diagnosis, and treatment services, and health risk assessment completion, as well as the continuity and coordination of care of our enrollees, among other duties. Her educational background includes a bachelor's degree in organizational leadership from Mountain State University in Beckley and an Associate of Science in Nursing from West Virginia Institute of Technology in Montgomery. Ms. Easter has a registered nursing license with the West Virginia Board of Nursing (license: [redacted]. She also has a case management certification and her advanced achievement in transplant management certification.	Yes
Elaina Wickas, BSN, RN	Quality Director	Elaina Wickas is a native West Virginian with 34 years of health care industry experience and 6 years of managed Medicaid experience in quality management roles in West	Yes

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		Virginia. Her expertise includes managed care quality improvement, managing large-scale teams and projects, regulatory and accreditation compliance, and audit oversight. Ms. Wickas also administers and oversees the QAPI and participates in its committee functions; oversees and supports accreditation activities, such as NCQA; participates in the QAPI Committee; initiates and maintains quality improvement projects; develops approaches to monitor provider performance in collaboration with Network and Provider Relations staff; and engages in activities related to APMs when they relate to quality of care measures and performance indicators. Ms. Wickas' educational background includes a Bachelor of Science in Nursing from West Virginia University in Morgantown. She has a registered nursing license from the West Virginia Board of Nursing (license: [redacted].	
Shannon White-Metz, MHA	Program Integrity Lead	Shannon White-Metz is a program integrity professional located in our Charleston office and a West Virginia native who was raised in Morgantown. With more than 20 years of health care and 3 years of managed Medicaid experience in West Virginia, she has the knowledge to promote and enforce compliance with state and federal laws and regulations. Her expertise includes experience in health care fraud investigation, strategic and tactical planning, risk analysis and mitigation, and regulatory compliance. In her role as program integrity lead, Ms. White-Metz is responsible for setting in place internal controls such as policies to prevent and detect fraud and abuse. She supports our SIU to investigate possible acts of fraud, waste, or abuse; serves as the primary contact person for all Bureau for Medical Services, CHIP program integrity, and Medicaid Fraud Control Unit record requests; and monitors provider fraud for underutilization of services and member/provider fraud for overutilization of services. Prior to joining Aetna, Ms. White-Metz served as a paralegal for the Leighway Consulting, where she performed legal research, case planning, development, and management. She has a Master of Hospital and Health Administration (MHA) from Xavier University in Cincinnati, Ohio, and a Bachelor of Business Administration from Marshall University in Huntington.	Yes

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
Dorsen McConnaughy, MBA	Network Development Director	Dorsen McConnaughy is an experienced network development executive who has lived in West Virginia for almost 30 years and has 40 years of health care industry experience and 19 years of managed Medicaid experience. His expertise includes network development, contract negotiation, provider relations, credentialing, provider billing, and process improvement. Mr. McConnaughy currently oversees network development and contracting activities for physical and behavioral health services. His focus includes maintaining the provider network in geographically accessible locations. He also ensures sufficient provider contracts for physical and behavioral health services as required by the Department's care network standards; provides written documentation of our provider network's adequacy; facilitates all provider contracting activities, including creative payment arrangements and APMs; and oversees provider contracting documents while supporting credentialing activities. Mr. McConnaughy's educational background includes a Master of Business Administration (MBA) from Franciscan University in Steubenville, Ohio and a Bachelor of Science in Business Administration from the University of Steubenville in Steubenville, Ohio.	Yes
Sarah White, MBA	Provider Relations Director	Sarah White is an experienced provider relations executive and a native West Virginian who is in our Charleston office. Ms. White has 17 years of health care industry experience and 11 years of experience in managed Medicaid in a provider relations manager or specialist role in West Virginia. Her expertise includes provider relations, credentialing, provider billing, and process improvement. Current duties include monitoring and responding to provider inquiries, complaints, and communications; developing training for contracted providers and their staff; developing and implementing our annual provider satisfaction survey; and ensuring the development, distribution, and maintenance of a provider manual. Ms. White has a Master of Business Administration and a Bachelor of Business Administration, both from Marshall University in Huntington.	Yes
Brad Liston, MS	Information Technology Director	Brad Liston is a native West Virginian and subject matter expert in information systems and is focused on operational effectiveness, enterprise initiatives, and any future integration activity. Mr. Liston has 22 years of health care industry	Yes

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		experience and 4 years of managed Medicaid experience in West Virginia. He has a broad understanding of business processes, information technology (IT) capabilities, IT operations, and IT integration. In his current role as the information technology director for Aetna Better Health of West Virginia, Mr. Liston is responsible for all systems, data, hardware activities, and technology delivery in support of Aetna Better Health of West Virginia business. Prior to joining Aetna, he served as a database administrator of management information systems for the State of West Virginia Department of Health and Human Resources, where he was responsible for data loads, backups, validation, and general financial and medical reporting. His work in West Virginia surrounding Medicaid and health care has been with financial and medical reporting, data integrity and transformation, and data security. Mr. Liston's educational background includes a Master of Science (MS) in Technology Management from Marshall University in South Charleston and a Bachelor of Science in Management Science from West Virginia University in Morgantown.	
To Be Hired Upon Contract Award	Member Services Director	Our West Virginia-based Member Services director will have at least three years' experience working with the public in an educational capacity on health insurance-related matters and call center experience and will hold a bachelor's degree or higher. This key staff member will oversee call center and enrollment and disenrollment activities, grievances, and other enrollee-related inquiries and will assist enrollees in obtaining covered services, handle questions and complaints, and ensure performance requirements among other duties.	No
To Be Hired Upon Contract Award	Claims Payment Director	Our West Virginia-based claims payment director will have at least three years' health insurer claims processing and encounters experience and have a bachelor's degree or higher. This key staff member will oversee all physical and behavioral health claims payment- and encounter-related activities to ensure timely, accurate provider claims payment and monitor claims processing activities for these services.	No
Jessica Feeney, MBA, M.Ed.	Encounter Data Integrity Manager	Ms. Feeney is an experienced manager of business information systems and analytics with excellent organizational and communication skills and a comprehensive background in information technology, data analysis, and	Yes

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		project management. She has been with our plan since 2012 and has been our encounter data integrity manager (manager of business information systems and analysis) since 2015. She contributes to our health plan's performance through impeccable research and analytics and is adept at analyzing data using appropriate data mining methods and creating clear and impactful reports and presentations. Ms. Feeney leads our Six Sigma initiatives to identify the root cause of errors and solutions to reduce errors while improving overall operational efficiencies. She supervises the department, including providing technical vision, mentoring, coaching, training, performance development plans, budgeting, and expenses. Her duties also include encounter oversight and submitting regulatory reports, requests for information, documentation, and ad hoc reports, or any other data required as requested by the Department within the given timeframes. She maintains reasonable safeguards against the destruction, loss, or alteration of any data in our possession; manages systems configuration, testing, and implementation activities; maintains our health information system that collects, integrates, analyzes, and reports necessary data for reporting purposes; and ensures timely, accurate, and complete claims payments and encounter-related activities. Ms. Feeney's educational background includes a Master of Business Administration in Information Systems from Wilmington University in Delaware; a Master of Education (M.Ed.) from Wilmington University, Delaware; and a Bachelor of Arts in Economics from the University of Delaware.	
To Be Hired Upon Contract Award	Community Engagement Director	Our West Virginia-based Community Engagement director will have at least three years' experience working with the public to better understand insurance and the health care environment and insurance, knowledge of the State and its population needs. This key staff member will have a bachelor's degree or higher and will be responsible for marketing, public relations, and community engagement activities. They will develop and maintain State-approved marketing policies and procedures, develop a written plan, and submit all marketing materials to the Department while ensuring prohibited marketing activities do not occur, among other duties.	No

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
LaKeisha Barron-Brown	MHT Member Advocate	LaKeisha Barron-Brown, our MHT member advocate, is based in Charleston, has 17 years of experience in health care working with low-income populations, and is well-versed in cultural awareness and sensitivity. A long-time resident of Charleston, Ms. Barron-Brown, has experience offering counseling and therapy to a broad range of clients, including providing support to patients referred by the Pregnancy Connections Program, navigating patients through the assessment, treatment, and management of drug and alcohol use during pregnancy, managing and coordinating various components in the Drug Court program, and working closely with the West Virginia Department of Health and Human Resources. As a key staff member, she is responsible for collaborating with our care management director and team, providing enrollees support related to enrollment, access, and continuity of care issues, aiding them with grievances or appeals activities, and assisting them in obtaining member materials in alternative formats. Ms. Barron-Brown holds a Master of Arts degree in counseling and a Bachelor of Arts degree in criminal justice both from Marshall University as well as a temporary permit from the West Virginia Board of Examiners in Counseling.	Yes
Diane Paletta, DDS	Dental Director	Dr. Diane Paletta is a West Virginian and an experienced professional who has practiced dentistry for over 40 years. She has 5 years of managed Medicaid experience, 5 years serving as a dental director, and over 40 years serving West Virginians. Her expertise includes general dentistry and Medicaid dental programs. Dr. Paletta has been treating various populations and making decisions about their dental care since she started as a dental hygienist in 1978. Currently, she oversees the administration of our dental services and performs oversight of the utilization of all covered dental services and utilization review decisions, as she is authorized to respond to dental clinical issues, utilization reviews, and dental quality of care inquiries. She served as a Professor of Pharmacology and Periodontology at the Division of Dental Hygiene at West Virginia University Tech and has served as clinical advisor for the West Virginia Board of Dentistry. Dr. Paletta earned her Doctor of Dental Surgery (DDS) from West Virginia University in Morgantown as well as a Bachelor of Science in Dental Hygiene (Magna Cum Laude). She has a	Yes

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		registered dental license with the West Virginia Board of Dentistry [redacted]	

Todd White
Chief Executive Officer



Todd White is a native West Virginian and currently serves as the chief executive officer of Aetna Better Health of West Virginia (Aetna), where he is responsible for delivering on all state contractual requirements. Additionally, he provides direction and oversight to more than 160 directly reporting staff. Under Mr. White's leadership, Aetna increased its service area from 16 counties in 2006 to all 55 counties in West Virginia by 2012. Aetna has also achieved the Commendable rating with the National Committee for Quality Assurance, the only West Virginia managed care organization currently scored at that level for more than three years. During his 13 years of Medicaid experience and his 24 years of health care industry experience, Mr. White has been responsible the implementation for new state programs and populations for Aetna; responsible for all contractual requirements and the financial performance of the health plan; and developed multiple partnerships with hospital systems, physician practices, and community and state-based agencies. One of them is the nation's first neonatal abstinence syndrome facility, Lily's Place. Prior to his experience working at the health plans, Mr. White worked with vulnerable youth at the West Virginia Rehabilitation Center. He is a long-time member of the West Virginia Association of Health Plans and serves as the secretary/treasurer. He earned his Bachelor of Science in Electrical Engineering and Technology from West Virginia Tech in Montgomery, West Virginia.

Experience

Aetna Better Health of West Virginia 2014 – Current
Chief Executive Officer

- Accountable for local market performance and the P&L responsibility for the Medicaid health plan and manages more than 160 direct reports
- Responsible for executive leadership and the overall direction and strategy for the health plan, including financial stability, operational performance, and compliance with all policies and contractual requirements
- Maintains strong and effective relationships with West Virginia providers, regulators, advocates, trade associations, and community leaders
- Attends in person, upon Department request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers
- Responsible for implementation of new state programs and populations into the health plan model
- Responsible for accreditation and audit results for and the financial performance of the plan
- Responsible for all contractual requirements to be met for the plan

Todd White

Coventry Health Care of West Virginia, Inc 2001 – 2014

Medicaid Director

- Was responsible for the Medicaid program leadership and the overall direction and strategy for the health plan, including financial stability, operational performance, external quality audits, and compliance with all policies and contractual requirements
- Led development and execution of short- and long-term Medicaid strategic objectives throughout the plan, including program and geographical expansions
- Directed medical cost management initiatives across all functional areas
- Advanced strong and effective relationships with providers, regulators, advocates, legislative members, and community leaders
- Expanded the West Virginia Medicaid market from 16 counties to all 55 counties in the state
- Responsible for all contractual requirements
- Responsible for value-based agreements with contracted providers
- Attended all State Medicaid managed care meetings and was the primary contact for the State Medicaid agency
- Managed the community development program for the plan

Senior Financial Analyst

- Responsible for budgeting, federal and state reporting, provider rate development, managed care rate development, cost analyses, and provider profiling
- Prepared monthly expenditure schedules for legislative reporting and quarterly federal budget and expenditure report
- Developed and maintained the relationship with state agencies and programs
- Developed and tracked various metrics for performance/efficiency

Education

Bachelor of Science in Electrical Engineering and Technology from West Virginia Tech in Montgomery, West Virginia

Greg Carpenter, MA
Contract Liaison/Mountain Health Trust (MHT) Administrator



Greg Carpenter is a native West Virginian and experienced executive who has 13 years of health care industry experience and 6 years of managed Medicaid experience in West Virginia. His expertise includes interpersonal communication skills, sales management skills, and organizational and process improvement skills. In his role as the contract liaison/MHT administrator for Aetna Better Health of West Virginia, Mr. Carpenter is responsible for overall direction and day-to-day operations of the entire plan. Prior to joining Aetna, he served as West Virginia director of Medicare sales and service for The Health Plan, where he was responsible for directing and overseeing the activities of the Medicare sales department in the state. Mr. Carpenter also serves at Cross Baptist Church, and earned his Master of Arts in Theology from Liberty Baptist Theological Seminary and Graduate School in Lynchburg, Virginia where he graduated Cum Laude. He also earned a Bachelor of Arts in Business Administration from West Virginia State University, in Institute, West Virginia.

Experience

Aetna Better Health of West Virginia, Inc. 2018 – Current
Contract Liaison/MHT Administrator
- Manages more than 80 direct reports
- Responsible for executive leadership and the overall direction and strategy for the health plan, including financial stability, operational performance, and compliance with all policies and contractual requirements
- Attends in person, upon Department request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers

The Health Plan 2014 – 2018
West Virginia Director of Medicare Sales and Service
- Was responsible for the Medicare sales program leadership and the overall sales direction and strategy for the health plan, including financial stability and compliance with all policies and contractual requirements
- Delivered a 75 percent increase in Medicare membership (Medicare Advantage Prescription Drug Contracting and Medicare Supplement)
- Nurtured relationships with brokers, sales managers, regulators, advocates, and community leaders

Independent Agency 2007 – Present
Medicare Sales Executive
- Developed a statewide reputation for being a Medicare and social security expert
- Delivered over $200,000 in Medicare sales revenue (employer group and individual sales)

Greg Carpenter, MA

Coventry Health Care of West Virginia, Inc. 2007 – 2008
Medicare Sales Manager

- Responsible for the Medicare sales program leadership and the overall sales direction and strategy for the health plan, including financial stability and compliance with all policies and contractual requirements

Education

- Master of Arts in Theology from Liberty Baptist Theological Seminary and Graduate School, Cum Laude, Lynchburg, Virginia
- Bachelor of Arts in Business Administration from West Virginia State University, Institute, West Virginia

Licensures and Certifications

Registered Insurance License, West Virginia Life and Health Insurance License [redacted]

Tina Bailes
Chief Financial Officer



Tina Bailes is a West Virginia native who grew up in Parkersburg and Charleston. She is an experienced executive leader with 21 years of health care industry experience and 5 years of managed Medicaid experience in West Virginia. Her expertise includes in-depth knowledge of Medicaid financing and programs and federal and statutory reporting requirements, as well as a strong financial and auditing background. In her role as chief financial officer for Aetna Better Health of West Virginia, Ms. Bailes is accountable for the day-to-day management of financial operations and ensuring that the health plan operates with sound financial and operating controls. Prior to joining Aetna, Ms. Bailes served various roles within the Bureau for Medical Services during her 16-year tenure at the State with her last role serving as the Deputy Commissioner of Finance and Administration. Her responsibilities included fiscal oversight of the $3 billion Medicaid service and administrative budget. Her educational background includes a Bachelor of Science in Business Administration from West Virginia State College, and she is a certified public accountant.

Experience

Aetna Better Health of West Virginia 2014 – Current
Chief Financial Officer

- Responsible for the oversight of the vendor's provider payment arrangements, including alternative payment models
- Supports health plan leadership in establishing and execution of market strategy for growth and profitability
- Serves as financial contact for state regulatory agency
- Accountable for day-to-day management of financial operations as well as monitoring and reporting of business goals and objectives
- Ensures local business operates effectively with sound financial analysis and reporting as well as appropriate financial and operating controls
- Directs the monthly financial close and preparation, review, and reconciliation of financial statements and communicates related information to local and segment management

Department of Health and Human Resources, Bureau for Medical Services 1996 – 2014
Deputy Commissioner, Finance, and Administration

- Responsible for fiscal oversight of $3 billion Medicaid service budget and $100 million administrative budget
- Responsible for budgeting, federal, and state reporting; provider rate development; managed care administration, rate development, drug rebate invoicing and collections, administrative contracting, Medicare buy-in programs, provider accounts receivable, accounts payable, and procurement activities
- Served as the legislative liaison for the Bureau for Medical Services
- Presented monthly at legislative interim meetings and annual House and Senate Finance Committee budget hearings

Tina Bailes

Chief Financial Officer

- Supervised accounting staff responsible for budgeting, federal, and state reporting; provider rate development; managed care rate development; drug rebate invoicing and collections; administrative contracting; provider accounts receivable; and accounts payable
- Prepared monthly expenditure schedules for legislative reporting and quarterly federal budget and expenditure report
- Prepared fiscal notes for Department's response to proposed legislation
- Coordinated and prepared supporting schedules for OMB A-133 Single Audit

Program Integrity Manager

- Supervised full-time audit staff responsible for monitoring program compliance
- Developed fraud, waste, and abuse cases through data mining and analysis of supporting medical records or documents
- Provided direct oversight and monitoring of fraud and abuse contractor including coordination of review initiatives and policy interpretation, validation of algorithm results, and recoupment of overpayments
- Provided program, policy, and claims analysis support to the U.S. Attorney General Office and the Medicaid Fraud Control Unit

NiSource 1999 – 2000
Oil and Gas Accountant

West Virginia Bureau of Employment Programs 1998 – 1999
Financial Reporting Specialist

Department of Health and Human Resources 1996 – 1998
Program Integrity Accountant

Education

Bachelor of Science in Business Administration, West Virginia State College, Institute, West Virginia

Licensures and Certifications

Certified Public Accountant

Alva "Fuzzy" Page III, Esq.
Compliance Officer



Alva "Fuzzy" Page III, Esq. is an executive with extensive health care law experience and success in the areas of government affairs and compliance. Mr. Page is a West Virginia native who was raised in Kanawha County. He has 15 years of health care and Medicaid industry experience and 3 years of managed Medicaid experience in West Virginia. His expertise includes experience in Medicaid matters in federal and circuit courts, strategic and tactical planning, cross-functional leadership, risk analysis and mitigation, and regulatory compliance. Mr. Page served as the General Counsel for the West Virginia Department of Health and Human Resources/Bureau for Medical Services, where he helped to administer the $4-billion-a-year West Virginia Medicaid program budget and advised the Commissioner on complex legal issues involving all aspects of Medicaid. During his time as both an Assistant Attorney General and the General Counsel for the Bureau for Medical Services, he worked closely with the Bureau for Children and Families on individual cases as well as joint policy matters. His educational background includes a Doctor of Jurisprudence from Capital University School of Law in Columbus, Ohio, and a Bachelor of Science in Accounting from Salem-Teikyo University in Salem, West Virginia.

Experience

Aetna Better Health of West Virginia 2015 – Current
Compliance Officer

- Promotes and enforces compliance with state/federal laws and regulations related to policies affecting Aetna's contract with the State of West Virginia to provide Medicaid managed care to members
- Audits, investigates, trains/educates, enforces, and provides ongoing consultation on compliance issues impacting Medicaid managed care contract with the State of West Virginia
- Ensures that compliance risks are addressed and corrective actions are taken, as appropriate
- Oversees the development of policies and procedures needed in response to new laws and/or regulations that have been enacted by leading the Policy & Procedure Committee
- Creates internal controls, policies, and procedures to prevent and detect fraud and abuse
- Oversees the Quarterly Compliance Committee
- Develops a formal Medicaid compliance plan with clear goals, assignments, measurements, and milestones
- Manages and develops staff

West Virginia Department of Health and Human Resources/ Bureau of Medical Services 2009 – 2015
General Counsel

- General counsel to the single state agency charged with administering the $4-billion-a-year West Virginia Medicaid program

Alva "Fuzzy" Page III, Esq.

- Advised commissioner and deputy commissioners on complex legal issues involving all aspects of Medicaid; this included provider reimbursement and legal analysis on all relevant statutes and regulation involving the Affordable Care Act
- Negotiated with the federal government (Centers for Medicare and Medicaid Services [CMS]) on how the Bureau administered the West Virginia Medicaid program
- Appeared before the West Virginia legislature and various legislative committees to provide detailed explanation on matters involving the Medicaid program
- Directed all litigation involving the Bureau
- Successfully negotiated a settlement with federally qualified health centers regarding reimbursement methodology
- Coordinated with the West Virginia Medicaid Fraud Control Unit on cases involving fraud and abuse

Assistant Attorney General for the Bureau of Medical Services 2003-2009

- Served as litigation counsel on all matters to the West Virginia Medicaid agency; these matters included administrative appeals for both providers and members, litigation in West Virginia Circuit Court, litigation in Federal District Court, and arguments made at the West Virginia Supreme Court of Appeals
- Assisted in successful defense of a $23 million disallowance brought by the CMS services for school-based health services provided under the Medicaid program
- Served as lead counsel on two class action cases involving home- and community-based services offered through the Medicaid program

Miller, Snyder, Weiler, and Walters 1999 – 2003
Associate Counsel

- Served as an associate attorney for small labor defense firm
- Handled various employment matters for small businesses, including representation in administrative hearings and litigation in the West Virginia Circuit Court and West Virginia Supreme Court of Appeals
- Drafted employer handbooks for small businesses to use for employee benefits
- Successfully litigated breach of contract cases

Education

- Doctor of Jurisprudence, Capital University School of Law, Columbus, Ohio
- Bachelor of Science in Accounting, Salem-Teikyo University, Salem, West Virginia

Licensures and Certifications

Registered License, West Virginia Bar (License [redacted]

Donald Gibbon, DO
Chief Medical Officer/Medical Director



Donald Gibbon, DO, is an experienced executive who has practiced medicine for 20 years. He has six years of managed Medicaid experience, six years serving as a medical director, and five years serving West Virginians. As a lifelong resident of Appalachia, Dr. Gibbon understands the health care needs of the most vulnerable people in West Virginia and served on his county's Children and Youth Services multidisciplinary team, where they worked with many foster children and their foster families. He was also the physician in charge at the county's Children's Advocacy Center. In addition, Dr. Gibbon served as the EPIC-SCAN educator for seven counties in Pennsylvania, where he trained other physicians to identify suspected child abuse and neglect and has served on court cases involving abuse as an expert witness for the prosecution. From routine complaints to physical abuse, sexual abuse, suicidal ideation and attempts, trauma, and other behavioral issues, Dr. Gibbon, as an emergency medicine physician for over 20 years, has treated children and adults of all ages. He has also worked with enrollees and patients to support them in their recovery from drug and alcohol use for more than 20 years and served as an Open Door (alcohol and other drug treatment center) board member from 1997 to 2006 and past president from 2001 to 2003. His expertise includes leadership roles in the emergency, occupational, and urgent care medicine fields, adult and child trauma treatment, and substance use disorder arenas. Dr. Gibbon was also intimately involved in the collaboration between Aetna Better Health of West Virginia and the Bureau of Medicaid Services for the development of their opioid management plan. Dr. Gibbon currently serves as the chief medical director of Aetna Better Health of West Virginia, where he is responsible for leading strategic activities concerning quality of care, utilization management, network management, and clinical policies.

Experience

Aetna Better Health of West Virginia 2015 – Current
Chief Medical Officer/Medical Director

- Develops and implements strategies for utilization management, quality improvement, network management, and clinical policies to drive excellence in patient care
- Leads a team of medical directors and other clinical staff
- Attends in person, upon Department request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers
- Responds to requests of the Department's medical director or contract administrator
- Performs utilization management activities in collaboration with the medical management director and behavioral health medical director
- Participates on the Quality Assurance and Performance Improvement Committee
- Provides oversight of care to children and adults in their crisis levels of care
- Leads Aetna's Medicaid organization plans in their strategy against opioid abuse and serves on the Opioid/Substance Use Disorder Program Development team
- Leads Aetna's Medicaid organization in their strategy to improve influenza vaccination rates
- Served as a trainer for Aetna medical directors nationwide

Donald Gibbon, DO

- Served as the featured physician in Aetna's Utilization Management Rounds training video

Coventry Health Care 2009 – 2015
Medical Director
- Provided input into the development, implementation, and revision of clinical policies to ensure compliance with regulations
- Collaborated with vice presidents to help define market strategy
- Represented the company at state, regulatory; and other meetings
- Participated in case management and provided consultation and clinical review for members and providers
- Provided oversight of care to children and adults in their crisis levels of care
- Identified opportunities to implement best practice approaches and introduce innovations

Indiana Regional Medical Center (Indiana, PA) 1997 – 2011
Emergency Services Director; Occupational Health Services Director; Bariatric Center Medical Management Director; Emergency Department Physician; Occupational Health Physician; UrgiCare Physician
- Served as a physician advisor through teaching, consulting, and advising the Care Management department, the medical center, and medical staff regarding physician practice patterns, documentation, over -and under-utilization of resources, medical necessity, level of care and length of stay, compliance rules and regulations, and collaborative relationships with payers and the community to meet goals for both quality and cost of care
- Co-developed the nuclear/chemical/biological response plan for the facility
- Served as the primary physician for the initial UrgiCare practice that opened and developed it into a highly successfully practice
- Oversaw the construction of a new $5 million emergency department
- Increased patient satisfaction scores for emergency management to the top 10 percent in the country and treated patients in emergent and trauma situations
- Served as Open Door (alcohol and other drug treatment center) former board member and past president from 2001 to 2003

Education
- Doctor of Osteopathy, Kirksville College of Osteopathic Medicine, Kirksville, Missouri
- Bachelor of Science in Biology, Mercyhurst College, Erie, Pennsylvania

Licensures and Certifications
- Registered Medical License, West Virginia Board of Medicine (License [redacted]
- Registered Medical License, Pennsylvania Board of Licensure (License [redacted]
- American Osteopathic Board of Emergency Medicine, Emergency Medicine, 2017
- Meets State requirement by having $10 million dollars' worth of liability insurance

Professional Memberships
American Osteopathic Association

Frank Angotti III, MD
Behavioral Health Medical Director



Frank Angotti III, MD, is a native West Virginian who is an experienced psychiatrist and behavioral health (BH) management professional with 10 years of health care industry experience and 6 years of managed Medicaid experience, including over three years serving the Medicaid population in West Virginia and over three years of managed Medicaid health plan experience, as well as leadership roles in child and adolescent psychiatry, behavioral clinic health, and substance use/trauma arenas. He has forged several relationships in the West Virginia community as it relates to appropriate therapeutic care for clients and available programs for those in need. He also has extensive experience managing children with complex BH needs under the Medicaid system and within the State of West Virginia. In his role as a BH medical director for Aetna, Dr. Angotti leads and supports the BH staff, works with upper management to develop the strategic direction of the department, and oversees the utilization management of BH, assisting in the resolution of presenting issues and reducing risk factors. Dr. Angotti also leads the Aetna National Medicaid initiatives in the improvement of foster care. Prior to joining Aetna, Dr. Angotti served as the child and adolescent psychiatrist for United Summit Center in Clarksburg, West Virginia, where most of the population received the Medicaid benefit. His educational background includes a Doctor of Medicine and a Bachelor of Science in Biology, both from West Virginia University. Dr. Angotti is also licensed to practice medicine in West Virginia, Kentucky, and North Carolina.

Experience

Aetna Better Health of West Virginia 2017 – Current
Behavioral Health Medical Director

- Oversees the utilization management, quality improvement, and network monitoring of the behavioral health activities of the population
- Develops services that improve care within the Aetna foster care membership
- Responds to BH clinical issues, utilization review, and behavioral quality of care inquiries
- Attends in person, upon Department request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers
- Communicates strategic plan and specific tactics to meet plan
- Identifies opportunities to implement best practice approaches and introduce innovations to better improve outcomes

United Summit Center, Clarksburg, WV 2013 – 2016
Child and Adolescent Psychiatrist

- Provided outpatient psychiatric services to children and adolescents
- Provided care to children and adults in their crisis levels of care
- Provided detox and stabilization to patients and coordinated care at the time of discharge

Frank Angotti III, MD

Cherry Hospital in Goldsboro, NC 2012 – 2013
Inpatient Child Psychiatrist
- Responsible for evaluation and treatment of children with complex BH needs, working within a multidisciplinary team
- Provided longer term and subacute services for those who were difficult to find placement

Education
- Fellow in Child and Adolescent Psychiatry, University of North Carolina Hospitals, Department of Psychiatry, Chapel Hill, North Carolina
- General Psychiatry Residency, University of North Carolina Hospitals, Department of Psychiatry, Chapel Hill, North Carolina
- Doctor of Medicine, West Virginia University School of Medicine, Morgantown, West Virginia
- Bachelor of Science in Biology, West Virginia University, Eberly College of Arts and Sciences, Morgantown, West Virginia

Licensures and Certifications
- Registered Medical License, West Virginia Board of Medicine [redacted]
- Registered Medical License, Kentucky Board of Licensure [redacted]
- Registered Medical License, North Carolina Medical Board [redacted]
- American Board of Psychiatry and Neurology, Child, and Adolescent Psychiatry, 2015
- American Board of Psychiatry and Neurology, Psychiatry, 2011

Professional Memberships
- American Academy of Child and Adolescent Psychiatry
- American Psychiatric Association

Kimi King, BSN, RN
Medical Management Director



Kimi King is a sixth-generation West Virginian who is also an experienced clincial services executive. Ms. King has 35 years of health care industry experience and 11 years of managed Medicaid experience in West Virginia. Her expertise includes nursing, clinical management, accreditation preparation, and strategic insights in the medical management arena. In her role as medical management director for Aetna Better Health of West Virginia, Ms. King is responsible all areas of medical management for the Medicaid health plan. Prior to joining Aetna, she served as the director of concurrent review and case management for Coventry Health Care, where she managed concurrent review for five states. Throughout her professional career, Ms. King has worked with pregnant mothers with substance use disorder and with babies with neonatal abstinence syndrome (NAS) in West Virginia. She also developed and implemented programs for babies with NAS and high-risk youth in the state. Her educational background includes a Bachelor of Science in Nursing from Alderson Broaddus University in Philippi, West Virginia.

Experience

Aetna Better Health of West Virginia 2015 – Current
Medical Management Director

- Responsible for the operations of the utilization management program, including oversight and management of processing referrals and pre-authorization requirements, as well as familiarity with appeals procedures
- Responds to requests of the Department's medical director or contract administrator
- Implements best practice programs for Aetna
- Serves as a member of several state task forces and core committees at Aetna
- Maintains utilization cost metrics and ensures quality standards
- Institutes process improvements in managing retrospective and claim review processing based on participation in risk assessment of program
- Conducts trainings and meetings to remain informed about evidence-based practices, changes in policies, and availability of effective resources

Coventry Health Care of West Virginia, Inc. 2008 – 2015
Director of Health Services

- Responsible for all areas of medical management for the Medicaid product in West Virginia
- Managed prior authorization, case management (CM), and utilization management (UM)
- Implemented best practice programs for the health plan
- Implemented the UM/CM regionalization pods and neonatal abstinence program
- Maintained utilization cost metrics
- Ensured quality standards

Kimi King, BSN, RN

Director of Concurrent Review and Case Management
- Managed concurrent review for five states: Ohio, West Virginia, Delaware, Maryland, and Pennsylvania
- Managed product lines for Medicaid, Medicare, and Commercial
- Managed case management for West Virginia
- Maintained state accreditation for Medicaid in West Virginia
- Developed and maintained the relationship with state agencies and programs
- Managed 5 direct reports and over 50 total employees
- Maintained and ensured National Committee for Quality Assurance (NCQA) standards
- Developed and tracked various metrics for performance/efficiency

Manager of Health Services
- Managed utilization departments in Charleston and Wheeling, West Virginia
- Managed Case Management and Concurrent Review staff
- Tracked and reported plan performance
- Maintained and ensured NCQA standards
- Managed product lines for Medicaid, Medicare, and Commercial

Charleston Area Medical Center, General Division 2006 – 2008
Manager, Trauma Unit, Trauma Pediatric Unit, and Trauma Surgical Clinic
- Planned, directed, implemented, coordinated, and improved services for above units
- Performed facility and staffing utilization reviews
- Participated in a patient flow project
- Ensured quality patient care
- Ensured professional growth of approximately 78 staff members

Education
Bachelor of Science in Nursing from Alderson Broaddus University in Philippi, West Virginia

Licensures and Certifications
- Registered Nursing License, West Virginia Board of Nursing (License [redacted]
- Six Sigma Certification, Green Belt (2007)

Johna Easter, RN, CCM
Care Management Director



Johna Easter is an experienced care management executive who is a native West Virginian and grew up in Charleston. Johna has 36 years of health care industry experience, 26 in managed care, and 5 years of managed Medicaid experience in West Virginia. Her expertise includes nursing, clinical case management, transplant case management, and strategic insights in the medical management arena. She has forged several relationships in the West Virginia community as it relates to coordinating care for members. In her role as care management director for Aetna Better Health of West Virginia, Ms. Easter is responsible for overseeing the day-to-day operations of staff members, strategic planning, and developing new care coordination programs. Prior to joining Aetna, Ms. Easter served as the director of care management for HealthSmart Care Management Solutions, where she was responsible for supervising a staff of nurses performing precertification and case management services for clients including PEIA and the Children's Health Insurance Program. She also served as a primary care manager communicating with members and their providers to develop individualized care plans. She obtained her case management certification (CCM) in 2000 and her advanced achievement in transplant management certification in 2013. Ms. Easter was a staff/charge nurse at Thomas Memorial Hospital, where she interacted with and treated all people, including the foster care and Medicaid populations. Throughout her professional career, Ms. Easter has treated and served children in West Virginia, which includes those in foster care. Her educational background includes a bachelor's degree in organizational leadership from Mountain State University in Beckley, West Virginia, and an Associate of Science in Nursing from West Virginia Institute of Technology in Montgomery, West Virginia.

Experience

Aetna Better Health of West Virginia 2015 – Current
Care Management Director

- Oversees day-to-day care management program operations, including but not limited to management and integration of care through the member's primary care provider, referral processes for medically necessary services and socially necessary services, provision of Early and Periodic Screening, Diagnosis, and Treatment services, and health risk assessment completion
- Establishes and monitors care coordination staffing ratios and related activities
- Oversees the continuity and coordination of care of members within this program
- Manages admissions and discharges for members and assists in resolution of presenting issues within the framework of medication adherence, treatment planning, medical necessities, and access to appropriate levels of care
- Applies clinical judgement and strategies that reduce risk factors and address clinical indicators that impact care planning and member issue resolution while collaborating with caseworkers
- Conducts trainings and meetings to remain informed about evidence-based practices, changes in policies, and availability of effective resources

Johna Easter, RN, CCM

HealthSmart Care Management Solutions 1994 – 2015

Director of Care Management

- Responsible for oversight of the day-to-day care management operations and supervision of staff
- Performed project management, client liaison, planning, and reporting duties
- Monitored and evaluated the care management program

Manager of Medical Management

- Responsible for the direct supervision of the registered nursing staff that performed precertification and case management services
- Prioritized workloads and produced reports and invoices
- Responsible for developing and updating departmental policies and procedures
- Monitored and evaluated the medical management program

Registered Nurse Case Manager/Utilization Management Nurse

- Responsible for critique of claims for medical necessity and case management of catastrophic cases
- Served on the Policy Committee
- Reviewed claims and charts for possible audit candidates, precertification of inpatient admissions and concurrent reviews, and outpatient services
- Trained new staff members
- Monitored and evaluated the care management program

Thomas Memorial Hospital 1990 – 1994

Care Manager and Staff/Charge Nurse

- Served as a per diem care manager when necessary, treating and interacting with the foster care and Medicaid populations
- Responsible for supervision of staff and patient care, IV therapy, medication administration, and treatments and procedures on a 30-bed medical/surgical/telemetry unit
- Served on the Discharge Planning Committee
- Coordinated the patient medication education program
- Conducted critical care classes

Education

- Bachelor's degree in Organizational Leadership, Mountain State University, Beckley, West Virginia
- Associate of Science in Nursing, West Virginia Institute of Technology, Montgomery, West Virginia

Licensures and Certifications

- Registered Nursing License, West Virginia Board of Nursing (License [redacted]
- Certification for Case Management (License [redacted]

Elaina Wickas, RN, BSN
Quality Director



Elaina Wickas is a native West Virginian who was raised in the Point Pleasant area. She is a results-oriented and versatile leader with 34 years of health care industry experience and 6 years of managed Medicaid experience in West Virginia. Her expertise includes managed care quality improvement, managing large-scale teams and projects, regulatory and accreditation compliance, and audit oversight. In her role as quality director for Aetna, Ms. Wickas is responsible for developing and implementing the Quality Assessment and Performance Improvement (QAPI) programs and policies in addition to running the Department's operations. Prior to joining Aetna, she served as the director of quality improvement for the Mid-Atlantic Region for Coventry Health Care, where she coordinated and supervised activities that promoted continuous quality improvement and monitored the agency's compliance. Ms. Wickas' educational background includes a Bachelor of Science in Nursing from West Virginia University in Morgantown, West Virginia.

Experience

Aetna Better Health of West Virginia 2014 – Current
Quality Director

- Develops, administers, and oversees the quality management processes and initiatives, QAPI program, and Healthcare Effectiveness Data and Information Set operations
- Manages a staff of eight employees
- Responsible for compliance with the state Medicaid contract, including annual External Quality Review Organization audits
- Is responsible for all aspects of National Committee for Quality Assurance (NCQA) survey readiness from application through IRT submission
- Serves as an accreditation subject matter expert with the Aetna Medicaid organization
- Oversees and participates in all local committees that support the QAPI program
- Participates in the development of approaches to monitoring provider performance, in collaboration with the Network and Provider Relations staff
- Initiates and maintains quality improvement projects that focus on quality indicators
- Engages in activities related to alternative payment models as they relate to quality of care measures and performance indicators

Aetna Inc. 2013 – 2014
Director, Health Care QM for Accreditation

- Served as a member of Aetna's national Quality Management (QM) team, managing a staff of 6 employees in locations across the United States
- Was responsible for NCQA accreditation readiness for Aetna Corporate NCQA Survey annual submissions
- Was responsible for the mock audit process to prepare all Aetna plans for local NCQA accreditation surveys
- Managed Aetna's patient safety program as well as additional QM work plan requirements in order to meet regulatory and accreditation requirements

Elaina Wickas, RN, BSN

Coventry Mid-Atlantic Region 2012 – 2013
Director, Quality Improvement

- Managed a staff of 11 employees in 5 locations in Pennsylvania, West Virginia, and Delaware
- Performed daily oversight of NCQA accreditation activities for Coventry Health Care's Mid-Atlantic Region
- Managed ongoing survey readiness preparation for renewal surveys in Pennsylvania and West Virginia as well as 'new' survey preparation for preferred provider organization exchange business in all states and first survey readiness for Delaware/Maryland health plan
- Managed all aspects of survey readiness from application process, mock audits, management of all sections of ISS tool, and onsite audit preparation
- Managed all credentialing and disease management oversight in all states in the region

Coventry Health Care 2007 – 2012
Director, Quality Improvement

- Managed a staff of 16 employees in 3 locations across Pennsylvania
- Performed daily oversight of all quality improvement operations statewide including quality improvement (QI) program and process development, credentialing, and disease management functions
- Developed and monitored clinical performance metrics
- Led performance improvement operational meetings and drove initiatives toward improvement of Centers for Medicare & Medicaid Services (CMS) STAR ratings
- Served on the Corporate QI team that discussed strategies for ensuring compliance with NCQA, CMS, and Utilization Review Accreditation Commission requirements
- Managed the credentialing and utilization management delegates as well as Health Insurance Portability and Accountability Act of 1996-certified vendors
- Managed compliance with Pennsylvania Department of Health and Department of Public Welfare Quality and Credentialing requirements

Coventry Health Care 1990 – 2007
QI Special Projects Coordinator

- Managed the administration of the interactive survey tool and facilitated NCQA survey process
- Facilitated various internal Quality Improvement Committees as well as meetings with external vendors such as behavioral health partners
- Prepared quality improvement documentation such as annual work plans, program description, program evaluation, policies and procedures, and various reports
- Conducted delegation oversight of various external vendors to evaluate their compliance with quality improvement, credentialing, and other plan requirements

Education
Bachelor of Science in Nursing, West Virginia University, Morgantown, West Virginia

Licensures and Certifications
Registered Nursing License, West Virginia Board of Nursing (License [redacted]

Shannon White-Metz, MHA
Program Integrity Lead



Shannon White-Metz is a program integrity professional and a West Virginia native raised in Morgantown. Shannon has 20 years of health care and 3 years of managed Medicaid experience in West Virginia. Her expertise includes experience in health care fraud investigation, strategic and tactical planning, risk analysis and mitigation, and regulatory compliance. In her role as program integrity lead for Aetna Better Health of West Virginia, Ms. White-Metz is responsible for serving as the primary contact person for all Department program integrity inquiries and issues as well as leading all compliance and program integrity efforts for the health plan. Prior to joining Aetna, she served as a paralegal for Leighway Consulting, where she performed legal research, case planning, development, and management. Her educational background includes a Master of Hospital and Health Administration from the Xavier University in Cincinnati, Ohio and a Bachelor of Business Administration from Marshall University in Huntington, West Virginia.

Experience

Aetna Better Health of West Virginia 2016 – Current
Program Integrity Lead/Senior Investigator of the Special Investigations Unit (SIU)

- Promotes and enforces compliance with state/federal laws and regulations related to policies affecting Aetna's contract with the State of West Virginia to provide Medicaid managed care to members
- Audits, investigates, trains/educates, enforces, and provides ongoing consultation on compliance issues impacting Medicaid managed care contract with State of West Virginia
- Ensures that compliance risks are addressed and corrective actions are taken, as appropriate
- Oversees the development of policies and procedures needed in response to new laws and/or regulations that have been enacted
- Creates internal controls, policies, and procedures to prevent and detect fraud and abuse
- Develops a formal Medicaid compliance plan with clear goals, assignments, measurements, and milestones
- Establishes and maintains SIU to investigate possible acts of fraud, waste, and abuse for all services provided under this contract
- Manages and develops staff
- Serves as the primary contact person for all Department program integrity and Medicaid Fraud Control Unit record requests
- Monitors provider fraud for underutilization of services and member/provider fraud for overutilization of services

Leighway Consulting 2015 – 2016
Contract Paralegal

Frost Brown Todd, LLC 2011 – 2015
Paralegal

Shannon White-Metz

MacCorkle Lavender, PLLC 2006 – 2011
Legal Assistant

Assurgent Medical Solutions, Inc. 2006 – 2009
Mid-Atlantic Director Marketing and Business Development (Per Diem)

Charleston Area Medical Center 2002 – 2005
Director of Physician Recruitment and Compensation

Integrated Health Care Providers, Inc. (CAMC) 2001 – 2002
Practice Administrator

Education

- Master of Hospital and Health Administration, Xavier University, Cincinnati, Ohio, 1993
- Bachelor of Business Administration, Marshall University, Huntington, West Virginia, 1991

Dorsen McConnaughy, MBA
Network Development Director



Dorsen McConnaughy is an experienced network development executive who has lived in West Virginia for almost 30 years and has 40 years of health care industry experience with 19 of those years in Medicaid. His expertise includes network development and management, contract negotiation, provider relations, credentialing, provider billing, and process improvement. In his role as the network development director for Aetna Better Health of West Virginia, Mr. McConnaughy is responsible for overseeing the network development and contracting activities for physical health (PH) and behavioral health (BH) services. Prior to joining Aetna, Mr. McConnaughy served as a network contractor for Wexford Health Sources, where he was responsible for negotiating contracts with hospitals, ancillaries, and physician groups to develop the provider network. His educational background includes a Master of Business Administration from Franciscan University in Steubenville, Ohio, and a Bachelor of Science in Business Administration from the University of Steubenville in Steubenville, Ohio.

Experience

Aetna Better Health of West Virginia 2019 – Current
Network Development Director

- Oversees day-to-day operations of Network Development staff members to ensure the development, education, reimbursement, and management of new and existing provider networks
- Establishes and maintains the provider network in geographically accessible locations for the population
- Ensures an optimal number of provider contracts for PH and BH services to maintain access to care in accordance with the Department's Medicaid managed care network standards
- Develops and submits written documentation of the adequacy of Aetna's provider network as required by the contract
- Facilitates PH and BH provider contracting activities, including creative payment arrangements and alternative payment models
- Oversees PH and BH contracting documents and addenda
- Supports the oversight of PH and BH provider credentialing activities
- Reports to the Department on access to care and network development needs for socially necessary services providers

Aetna Better Health of West Virginia 2005 – 2019
Senior Network Contractor/Manager

- Negotiated ongoing contracts with hospitals, ancillaries, and physician groups for development of provider network for commercial health maintenance organization/preferred provider organization, Medicare, and Medicaid products
- Negotiated out-of-network single case agreements for member access with non-contracted providers
- Addressed providers' concerns regarding reimbursement issues

Dorsen McConnaughy, MBA

Wexford Health Sources 2003 – 2005
Network Contractor
- Negotiated ongoing contracts with hospitals, ancillaries, and physician groups for development of provider network
- Addressed providers' concerns regarding reimbursement issues

UPMC Health Plan 2000 – 2003
Network Contractor
- Negotiated ongoing contracts with hospitals, ancillaries, and physician groups for development of provider network
- Addressed providers' concerns regarding reimbursement issues

Washington Health System 1989 – 1999
Manager of Patient Finance
Managed accounts receivable, billing, posting, credit, collections, insurance verification, pricing, regulatory compliance, reimbursement analysis, and financial reporting

Massillon Community Hospital 1987 – 1989
Manager of Patient Finance
Managed accounts receivable, billing, posting, credit, collections, insurance verification, pricing, regulatory compliance, reimbursement analysis, and financial reporting

Education
- Master of Business Administration, Franciscan University, Steubenville, Ohio
- Bachelor of Science in Business Administration, University of Steubenville, Steubenville, Ohio

Sarah White, MBA
Provider Relations Director



Sarah White is an experienced provider relations and network development executive who is a native West Virginian and grew up in Scott Depot. Ms. White has 17 years of health care industry experience and 11 years of managed Medicaid experience in West Virginia. Her expertise includes provider relations, credentialing, provider billing, and process improvement. In her role as the provider relations director for Aetna Better Health of West Virginia, Ms. White is responsible for overseeing the day-to-day operations of staff members, education, service, reimbursement, and management of existing provider networks, and ensuring all contractual metrics are met and/or exceeded. She also served as a senior provider relations representative for Coventry Health Care of West Virginia before it became part of Aetna; during that time, Ms. White was responsible for credentialing and contracting new providers as well as updating existing providers' credentialing and contracts. In her free time, Sarah volunteers at her church caring for children covered by both the Medicaid program and Children's Health Insurance Program in the nursery and youth group. Her educational background includes a Master of Business Administration and a Bachelor of Business Administration, both from Marshall University in Huntington, West Virginia.

Experience

Aetna Better Health of West Virginia 2008 – Current
Provider Relations Director

- Oversees day-to-day operations of Provider Relations staff members to ensure the development, education, service, reimbursement, and management of existing provider networks
- Manages a diverse team consisting of network managers and network consultants, as well as a credentialing analyst and network relations specialists
- Ensures that compliance risks are addressed and corrective actions are taken, as appropriate
- Optimizes interactions with providers and internal business partners to establish and maintain productive, professional relationships and partners on the development of business strategy and programs to support the operational plans
- Monitors and responds to provider inquiries, complaints, and communications
- Develops training for contracted providers and their staff in relation to the requirements of this contract and the special needs of the population
- Designs, develops, and implements an annual provider satisfaction survey
- Facilitates the production and distribution of communication documents such as the provider manual, fax/email blasts, mailings, surveys, and provider newsletter
- Coordinates presentations, display tables, and materials for various provider relations events, workshops, and forums

Sarah White

Coventry Health Care of West Virginia, Inc. Senior Provider Relations Representative
- Responsible for credentialing and contracting new providers as well as updating existing providers' credentialing and contracts
- Addressed providers' concerns regarding claims and reimbursement issues
- Performed site reviews as needed for recredentialing or quality of care issues
- Conducted reviews of provider records to ensure the information was current in the Coventry system
- Attended provider conferences and workshops as a representative of Coventry Health Care
- Assisted in delegated credentialing audits
- Coordinated with the Health Services department in outreach efforts to providers regarding available incentives and case management programs

Coventry Health Care of West Virginia, Inc. Provider Relations Representative
- Responsible for credentialing and contracting new providers as well as updating existing providers' credentialing and contracts
- Addressed providers' concerns regarding claims and reimbursement issues
- Performed site reviews as needed for recredentialing or quality of care issues
- Conducted reviews of provider records to ensure the information was current in the Coventry system
- Attended provider conferences and workshops as a representative of Coventry Health Care
- Assisted in delegated credentialing audits
- Coordinated with the Health Services department in outreach efforts to providers regarding available incentives and case management programs

CareFirst BlueCross BlueShield 2002 – 2008

Supervisor 1
- Supervised a team of 14 employees
- Oversaw annual compliance training processes for the team
- Performed annual performance reviews
- Performed site visits with hospitals in the Maryland/D.C. area to review and adjust claims or assist Provider Relations with contract negotiation issues
- Created policy and procedure manuals for the Proactive Service unit

Education
- Master of Business Administration, Marshall University, Huntington, West Virginia
- Bachelor of Business Administration, Marshall University, Huntington, West Virginia

Brad Liston, MS
Information Technology Director



As a native West Virginian and subject matter expert in information systems, Mr. Liston is focused on operational effectiveness, enterprise initiatives, and any future integration activity. He has 22 years of health care industry experience and 4 years of managed Medicaid experience in West Virginia. In addition, he has a broad understanding of business processes, information technology (IT) capabilities, IT operations, and IT integration. In his role as the information technology director for Aetna Better Health of West Virginia, Mr. Liston is responsible for all systems, data, hardware activities, and technology delivery in support of Aetna Better Health of West Virginia business. Prior to joining Aetna, he served as a database administrator of management information systems for the State of West Virginia Department of Health and Human Resources where he was responsible for data loads, backups, validation, and general financial and medical reporting. His work in West Virginia surrounding Medicaid and health care has been with financial and medical reporting, data integrity and transformation, and data security. Mr. Liston's educational background includes a Master of Science in Technology Management from Marshall University in South Charleston, West Virginia, and a Bachelor of Science in Management Science from West Virginia University in Morgantown, West Virginia.

Experience

Aetna Better Health of West Virginia 2015 – Current

Information Technology Director

- Submits required reports and requests for information, documentation, ad hoc reports, data certification forms, or any other data required as requested by the Department within the timeframes provided by the contract
- Maintains reasonable safeguards against the destruction, loss, or alteration of any data
- Manages systems configuration, testing, and implementation activities
- Maintains a health information system that collects, integrates, analyzes, and reports necessary data for reporting purposes
- Oversees all systems related activities, including but not limited to, the electronic medical record claims processing system and provider data system
- Develops and participates in presentation and consultation to existing and prospective customers, business partners, and internal business areas on information services, capabilities, and performance results
- Works closely with Contracting, IT, Operations, and Finance to deliver successful project implementation and integrating analytics strategy into the execution process, including program management, project controls, communications, and vendor oversight

Medical Economics Senior Consultant

- Supports the Finance Office during month-end closing and audits
- Develops complex reporting in support of financial strategic planning
- Reconciles revenue and membership
- Provides data analysis for medical claims/cost/trend reporting
- Tracks and monitors complex claims projects

Brad Liston

- Validates data from internal/external sources
- Serves as the data liaison between local office and state fiscal agents
- Coordinates with corporate data managers providing analysis and validation of state data and corporate reporting
- Supports corporate data managers in testing and validation during system upgrades and migration and maintains SQL query library

State of West Virginia, Department of Health and Human Resources 1997– 2015

Database Administrator for Management Information Systems

- Supported 30-35 Oracle databases for five bureaus/agencies
- Responsible for daily monitoring, management, and backup
- Performed user support and management and monthly/quarterly updates/patching
- Diagnosed O/S, database, and application errors and provided corrective action
- Installed, configured, deployed, and upgraded databases
- Implemented data transformation from disparate datasets to develop critical financial reporting
- Experienced with Cognos BI, Oracle Database, Oracle Warehouse Builder, Oracle Real
- Application Cluster, Oracle Discoverer, Oracle DataGuard, among others

Database Administrator for Bureau for Medicaid Services

- Support the Bureau's Oracle decision support system
- Developed provider cost reports, ad hoc reporting, and legislative budget forecasting and analysis
- Created reconciliation process for data warehouse against federal Centers for Medicare & Medicaid Services reports and the Bureau's QNXT system
- Assisted in data analysis between Bureau's QNXT system and data warehouse
- Accountable for backup of State Medicaid database
- Created and maintained Bureau's first website

Management Systems of West Virginia 1992 – 1997

Computer Programmer/User Support

- Maintained accounting software library consisting of 16 different modules including but not limited to accounts receivable, accounts payable, general ledger, job cost, and order entry
- Responsible for user support, hardware, and software diagnosis and correction
- Served as the liaison between clients and the industry support personnel
- Trained users on Lotus123, WordPerfect, and basic computer operations and functions
- Garnered an extensive background with UNIX, Windows operating systems, and COBOL programming

Education

- Master of Science in Technology Management, Marshall University, South Charleston, West Virginia
- Bachelor of Science in Management Science, West Virginia University, Morgantown, West Virginia

Jessica Feeney, MBA, M.Ed.
Encounter Data Integrity Manager



Jessica Feeney is an experienced manager of business information systems and analytics with excellent organizational and communication skills and a comprehensive background in information technology (IT), data analysis, and project management. She has been with our plan since 2012 and has been our encounter data integrity manager (manager of business information systems and analysis) since 2015. Ms. Feeney contributes to our health plan's performance through impeccable research and analytics and is adept at analyzing data using appropriate data mining methods and creating clear and impactful reports and presentations. Ms. Feeney leads our Six Sigma initiatives to identify root cause of errors while providing solutions to reduce errors and improve overall operational efficiencies. She supervises the department, including providing technical vision, mentoring, coaching, training, performance development plans, budgeting, and expenses.

Experience

Aetna 2015 – Current

Encounter Data Integrity Manager (Manager of Business Information Systems and Analysis)

- Responsible for the submission and integrity of state files and regulatory reports, including Mountain Health Trust Quarterly, 5010 electronic data interchange encounter files, and the monthly proprietary encounter file. This includes ensuring timeliness, accuracy, corrections, and completeness and oversight of Aetna and subcontractor data.
- Manages Analytics team responsible for the design, development, and delivery of health care information to internal and external stakeholders, including claims, care management, provider, and financial data
- Gathers business requirements and builds, tests, and deploys analytical reports, including univariate and multivariate statistical analysis, outlier identification, and data visualization
- Ensures strategic alignment between operations, finance, and IT projects and the organization's broader goals
- Assists in the development/direction of corporate strategy through data governance, analysis, and evaluation of revenue and cost drivers in conjunction with potential opportunities
- Drives cross-functional and cross-alliance integration of operational activities, including coordinating across workgroups, issue identification and resolution, problem solving, contingency planning, and decision-making
- Develops/participates in presentation/consultation to existing/prospective customers and the state.
- Leads Six Sigma initiatives to identify root cause of errors and solutions to reduce errors
- Supervises unit, including providing technical vision, mentoring, coaching, training, performance development plans, budgeting, and expenses

Informatics Analyst 2012 – 2015

- Reviewed contract requirements to design and report monthly, quarterly, semiannual, and annual data to meet regulatory compliance

Jessica Feeney, MBA, M.Ed.

- Collaborated with key stakeholders including Contracting, Health Services, Provider Relations, Operations, Finance, and Pharmacy, among others, to assess data and technology needs
- Performed trends and forecasting analysis on claims, utilization, and provider data
- Interpreted state contracts and documentation to determine state's payment system and files to create financial, risk score, and membership reconciliation
- Worked with large data sets; data mined and programmed in SAS, SQL, SSRS, Visual Basic, Power BI, and Access to track, report, analyze, and interpret different functional areas' data

Consultant 2004 – 2012

Technology and Reporting Consultant

- Extracted, collected, and analyzed provider practices' patient and financial data to determine insights into business costs, patient utilization, and current market conditions
- Recommended new avenues of business, which resulted in some businesses changing marketing avenues and expanding services; built and maintained company Internet sites
- Developed reporting to analyze businesses' financial progress, including accounts outstanding, expenses versus income, and product pricing

Wilmington Trust 1999 – 2004

Technology Analyst/Project Manager

- Led companywide projects from start to completion, finding the best possible solution fulfilling the time, financial, and quality goals defined by the company or business area need
- Defined project scope, developed proposals and detailed timelines, and created and delivered status reports
- Designed and presented final project data and recommendations to upper management and executives
- Performed business analysis, data manipulation, and financial analysis daily using Access, Excel, and SQL

Education

- Master of Business Administration in Information Systems, Wilmington University, Delaware, 2019
- Master of Education, Wilmington University, Delaware, 2004
- Bachelor of Arts in Economics, University of Delaware, Delaware, 1999

Licensures and Certifications

- Aetna Six Sigma Certification, Yellow and Green Belt
- Finance in Health Care (America's Health Insurance Plans)

Technology Skills

SAS, SQL, SSRS, Power BI, Quick Base, Access, Visual Basic, Visio, Microsoft Office Suite including Excel and PowerPoint, Crystal Reports, MS Project, SharePoint

LaKeisha D. Barron-Brown
Mountain Health Trust Member Advocate

Ms. LaKeisha D. Barron-Brown, a long-time resident of Charleston, has more than 17 years of experience offering counseling and therapy to a broad range of clients, including providing support to patients referred by the Pregnancy Connections Program; navigating patients through the assessment, treatment, and management of drug and alcohol use during pregnancy; managing and coordinating various components in the drug court program; and working closely with the West Virginia Department of Health and Human Resources.

Experience

Aetna Better Health of West Virginia 2020 – present
Mountain Health Trust Member Advocate
- Collaborates with the care management director and care coordinators
- Provides enrollee support related to enrollment, access, and continuity of care issues
- Supports enrollees throughout any grievances or appeals activities
- Assists enrollees in obtaining materials in alternative formats, as applicable
- Interacts with enrollees in a culturally sensitive manner

Thomas Memorial Hospital, South Charleston, West Virginia 2018 – 2020
Pregnancy Connections Therapist
- Provided management and supportive referral of patients referred to the Pregnancy Connections Program by medical, nursing, or ancillary practitioners, both from within the hospital and as outpatients, including patients referred for opioid treatment programs and detoxification
- Provided training for medical, nursing, and ancillary staff in the management of alcohol and other drug problems; navigated patients through the assessment, treatment, and management of drug and alcohol use during pregnancy
- Worked closely with Drug and Alcohol staff and other services, including emergency department, obstetrical departments, behavioral health services, and community agencies

Highland Hospital, Charleston, West Virginia 2017 – 2018
Therapist
- Provided individual, group, and family therapy for adolescent inpatient treatment
- Provided information for treatment team and discharge planning purposes; participated in family meetings to aide in the integration of information
- Provided crisis intervention to adolescent patients and families in acute distress
- Completed psychosocial assessments as needed; worked closely with the West Virginia Department of Health and Human Resources and the foster care system

West Virginia Supreme Court of Appeals, Charleston, West Virginia 2013 – 2017
Adult Drug Court Probation Officer
- Managed and coordinated various components in the drug court program
- Supervised staff and defendants; performed administrative functions such as long-range planning and budget requests; established procedures and oversaw day-to-day operations

LaKeisha D. Barron-Brown

- Developed and maintained a linkage with community primary liaison, the news media, and the general public, as well as ongoing development, evaluation, and functioning of programs
- Acted as a liaison between the drug court and representatives of other agencies
- Conducted initial intake and assessment and contacted the diversion manager and appropriate treatment provider to inform them of initial candidates' status

Kanawha County Sheriff's Office, Charleston, West Virginia 2012 – 2013
Drug Court Counselor

- Provided professional substance abuse counseling, education, and rehabilitative services to the full range and variety of referred offenders
- Worked closely with the drug court coordinator to develop effective programs
- Conducted comprehensive assessment of psychiatric history (e.g., onset, course, and effect of illness, past treatment and responses, and risk behaviors), mental status, and diagnosis; physical health and dental health; use of drugs or alcohol; education and employment; social development and functioning; activities of daily living

West Virginia State University Research and Development Corporation, Institute, West Virginia 2006 – 2012
Multicultural Counselor

- Provided personal and academic counseling to traditional and non-traditional students
- Developed and coordinated campus and community-wide events that address diversity awareness and social justice concerns
- Maintained a collaborate relationship with community agencies
- Provided counseling to students that have been sanctioned by Judicial Affairs
- Responsible for writing reports and making recommendations to Judicial Affairs regarding the status of the student

Education

- Master of Arts, Counseling, Marshall University, South Charleston, West Virginia, with specialization in Correctional Counseling, 2002
- Bachelor of Arts, Marshall University, Huntington, West Virginia, with emphasis in Criminal Justice/Corrections

Licensures and Certifications

Temporary Permit – West Virginia Board of Examiners in Counseling

Diane Paletta, DDS
Dental Director



Diane Paletta, DDS, a West Virginian, is an experienced professional who has practiced dentistry for over 40 years. She has 5 years of managed Medicaid experience, 5 years serving as a dental director, and over 40 years serving West Virginians. Her expertise includes general dentistry and Medicaid dental programs. Dr. Paletta has been treating children and making decisions about their dental care since she started as a dental hygienist in 1978. She served as a professor of pharmacology and periodontology in the Division of Dental Hygiene at West Virginia University Tech and has served as clinical advisor for the West Virginia Board of Dentistry. Dr. Paletta currently serves as the dental director of Aetna Better Health of West Virginia, where she is responsible for the oversight of the administration of dental services within the contract. Prior to joining Aetna, she served as the West Virginia dental director for SKYGEN USA. Dr. Paletta served as a Capitol City Give Kids a Smile volunteer and served as the chairperson for the West Virginia Donated Dental Services for the Handicapped Council. She also volunteers in the West Virginia community by restoring the mouths of abused spouses and children as part of the American Academy of Cosmetic Dentistry. She earned her Doctor of Dental Surgery (DDS) from West Virginia University in Morgantown, West Virginia, and a Bachelor of Science in Dental Hygiene, Magna Cum Laude, from West Virginia University as well. She is a member of several organizations such as the American Academy of Cosmetic Dentistry, American Association of Dental Boards, American Academy of General Dentistry, and the West Virginia Rural Health Development Council, among others.

Experience

Aetna Better Health of West Virginia 2019 – Current
Dental Director

- Performs oversight of the utilization of covered dental services under this contract
- Performs dental utilization review decisions and is authorized to respond to dental clinical issues, utilization review, and dental quality of care inquiries

SKYGEN USA 2013 – Current
West Virginia Dental Director

- Provides local clinical representation for SKYGEN USA
- Maintains a deep understanding of Medicaid dental plans and strong Medicaid clinical program knowledge in order to accurately review and provide authorizations through the Enterprise system
- Identifies aberrant conditions and trends related to reviewing provider authorization of dental services
- Refers SKYGEN Utilization Management staff to appropriate research and resolution
- Conducts clinical reviews, peer clinical reviews, and appeal considerations
- Uses resources available from SKYGEN Utilization Management staff to maintain current knowledge and understanding of dental coverage services requiring her review

Diane Paletta, DDS

West Virginia Board of Dentistry 2007 – 2014
Clinical Advisor

West Virginia University Tech, Division of Dental Hygiene 2006 – 2007
Professor of Pharmacology and Periodontology

Private Practice of Dentistry 1983 – 2005
General Dentist

Practice of Dr. Joseph Bowles 1978 – 1979
Dental Hygienist

Education
- Doctor of Dental Surgery, West Virginia University, Morgantown, West Virginia
- Bachelor of Science in Dental Hygiene, Magna Cum Laude, West Virginia University

Licensures and Certifications
Registered Dental License, West Virginia Board of Dentistry (License[redacted]

Professional Memberships
- American Academy of Cosmetic Dentistry
- American Association of Dental Boards
- American Academy of General Dentistry
- American Dental Association
- West Virginia Dental Association
- West Virginia Academy of General Dentistry
- West Virginia Board of Dentistry
- West Virginia Rural Health Development Council
- West Virginia University Accreditation
- Kanawha Valley Dental Society

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

ATTACHMENT 5: MANDATORY REQUIREMENTS

Instructions: The mandatory requirements must be met by the Vendor as a part of the submitted proposal. Failure on the part of the Vendor to meet any of the mandatory requirements will result in its disqualification of the proposal, at the sole discretion of the Department. The terms "must" and "shall" stipulate and identify a mandatory requirement. The Vendor is to demonstrate compliance with mandatory requirements in its proposal. If the Vendor's proposal meets the mandatory requirements, the Vendor's proposal will be included in the next part of the technical evaluation of this RFP. For mandatory requirements that necessitate a future action, the Vendor will respond in ***Attachment 7: Terms and Conditions*** with an attestation that it will meet all mandates. For mandatory requirements involving documentation to be submitted for this bid submission, Vendors must include that documentation with its technical proposal as part of this bid submission. The Vendor's narrative response for **Attachment 5** should not exceed 10 pages.

See the attached Microsoft Excel® file titled, "***MHT_Attachment_5_ Mandatory_Requirements.***"

Aetna attests to meeting all of the mandatory requirements found in **Attachment 5** in serving enrollees within the West Virginia Medicaid managed care programs, including the Mountain Health Trust (MHT), West Virginia Health Bridge, and the West Virginia Children's Health Insurance Program (WVCHIP), effective July 1, 2020.

Compliance with Applicable Requirements

MD001	The Vendor must comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement (SPA) and any modifications pursuant to changes to State policy, State or federal laws and regulations, waiver amendments, or State Plan amendments.
MD002	The Vendor must comply with all Service Level Agreements (SLAs), as indicated in the Service Provider Agreement (SPA).

Aetna acknowledges, understands, and will continue to comply with all applicable requirements outlined in this procurement in addition to the Service Provider Agreements (SPA) and all Service Level Agreements. We will also comply with any modifications required pursuant to changes to the policy, state or federal laws and regulations, waiver amendments, or State Plan amendments.

Acceptance of the Rate Established by the State

MD003	The Vendor must accept the rate established by the State on a per member per month (PMPM) basis for managed care physical health and behavioral health services.

Upon full disclosure of final rate and evaluation of rate adequacy, Aetna will accept the rate established by the State of West Virginia on a per member per month basis for managed care physical health and behavioral health services.

Physical Health and Behavioral Health Provider Network

MD004	The Vendor must establish a physical health and behavioral health provider network that provides adequate access, as defined by the Service Provider Agreement (SPA), and serves all counties in the State.

We will continue to meet requirements to maintain a physical health and behavioral health provider network that provides adequate access as defined by the SPA and serves all counties in the State.

Submission of Provider Contract Template and Addenda

MD005	The Vendor must submit its provider contract templates and addenda to the Department for approval.

Aetna will continue to submit provider contract templates and addenda to the Department for approval and respond timely to any questions or comments.

Submission of Value-Based Payment (VBP) Plan

MD006	The Vendor must submit an initial Value-Based Payment (VBP) plan to the Department and annually thereafter.

Aetna will submit an initial Value-Based Payment (VBP) plan to the Department and annually thereafter. Our approach to VBP aligns with the Bureau for Medical Services (BMS) goals through the use of contracts that achieve improved health outcomes for our enrollees.

Accreditation by the National Committee for Quality Assurance

MD007	The Vendor must be accredited by the National Committee for Quality Assurance (NCQA) no later than nine (9) months from its operational start date in the State.

Aetna was the **first West Virginia Medicaid plan** to achieve a **Commendable National Committee for Quality Assurance (NCQA) accreditation** as a Medicaid organization and the **only plan to maintain it without interruption since 2016**, with a current NCQA rating of 4.0.

Requested Supporting Documentation

MD008	The Vendor must provide all requested supporting documentation as specified by the Request for Proposal (RFP), and according to the requirements described in Section 3: General Terms and Conditions, as well as Appendix 4: List of Requested Documents.

We will provide all requested supporting documentation as specified by the Request for Proposal and according to the requirements described in **Section 3: General Terms and Conditions**, as well as **Appendix 4, List of Requested Documents** within the timeframes specified by the Department.

24-hour Access to a Provider or Service in Emergency Situations

MD009	The Vendor must provide twenty-four-hour access seven (7) calendar days a week to a provider or service in emergency situations.

We will continue to provide 24/7/365 access for medical, behavioral health, dental, and crisis stabilization services. In providing 24-hour access to services in emergency situations, we create incentives for providers in value-based purchasing contracts for provision of after-hours care. We provide specific education on after-hours resources, including urgent care services.

Monitoring Primary Care Provider Panels for Compliance

MD010	The Vendor must monitor Primary Care Provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) and West Virginia Children's Health Insurance Program (WVCHIP) limits of members assigned per PCP.

We will continue to monitor primary care provider (PCP panels for compliance with the BMS and WVCHIP limits of members assigned per PCP, for applicable populations. We take seriously and comply with PCP panel requirements to assure members receive the attention and access needed to optimize their health outcomes. We review open panel status to confirm where we can assign new members and identify providers that have reached their capacity and/or referral limits on an ongoing basis. We have an enrollee limit built into our electronic system for each PCP of 2,000 enrollees. If BMS or WVCHIP notifies us that a provider has exceeded their panel limit across all MCOs, their panel will be closed to new members. Aetna acts upon every PCP assignment by analyzing the potential PCP's panel to ensure the panel has not reached the

maximum number of members assigned. If the maximum panel size has been reached, we will assign new members to an alternative PCP that will meet the member's needs.

Network Standards Documentation and Geographic Mapping Reports

MD011	The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA).

Aetna acknowledges, understands, and will continue to comply with the requirement to submit network standards documentation and geographic reports in accordance with the reporting instructions within the SPA. On an annual basis, we provide network standards documentation to the Department ensuring that our network meets physical and behavioral needs.

Screening Processes

MD012	The Vendor must establish screening processes (per applicable federal and State requirements, as defined by the Department) designed to ensure that the Vendor does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal healthcare programs.

We have established screening processes to make certain we do not utilize subcontractors that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal health care programs. Our background screening process includes validation that the potential entity is not on the Medicare or Medicaid exclusion list nor was found liable for or currently facing criminal or civil action for False Claim Act violations; Medicare, Medicaid, consumer, or health care fraud; or similar findings in any jurisdiction. We obtain the ownership information for our subcontractors and check them against the Foreign Earned Income Exclusion (FEIE) database and require all of our subcontractors to complete an initial screening of the FEIE database for all of their contracted providers.

Public Meetings and Other Events

MD013	The Vendor must participate in public meetings and other events at the request of the Department.

We will continue our existing community collaborations and participation in public meetings and events at the request of the Department. Chief Executive Officer of Aetna Better Health of West

Virginia Todd White instills a collaborative, **neighbor helping neighbor** approach to create solutions for complex health concerns. Donald Gibbon, DO, chief medical officer (CMO)/medical director, collaborates with Department staff and other MCO CMOs within standing meetings to improve and streamline medical processes across the Medicaid enrollee population. Dr. Gibbon and Frank Angotti III, MD, our behavioral health director, are intimately involved in the collaboration between Aetna and BMS for the development of their opioid management plan and their Safe and Effective Management of Pain Initiative. Under the new MHT contract, we will engage and collaborate with WVCHIP in meetings upon state direction.

Current and Future Security Policies and Procedures

MD014	The Vendor must comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT), which can be found at the following links: http://www.wvdhhr.org/mis/policies.asp https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx http://www.state.wv.us/admin/purchase/privacy/default.html

Aetna acknowledges, understands, and will continue to comply with, all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT). Aetna exceeds industry standards with robust information security policies, procedures, and standards based on the information we need to protect, who uses the information, and laws/regulations that apply to Aetna and its industry.

Compatibility with Versions and Standards

MD015	The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.

Aetna complies with West Virginia standards and requirements for file formats, ensuring compatibility with the most current WVOT supported versions and standards. Aetna has had no local technology breaches and will continue that level of commitment.

Accepting the Medical Assistance Identification

MD016	The Vendor must ensure that the health information system accepts the Medical Assistance Identification (MAID) generated by the Department for all members for data collection and billing purposes.

Aetna's health information system accepts the Medical Assistance Identification (MAID) generated by the Department for all members for data collection and billing purposes. We support the State's efforts to utilize the MAID to integrate MCO data into a warehouse for better coordination of member care and reporting of member outcomes.

Producing Reports in Accordance with Standardized Reporting Template

MD017	The Vendor's information management system must have the capability to produce reports in accordance with the State's Medicaid Fraud Control Unit's (MFCU's) standardized reporting template upon request, as referenced in Appendix 5.

Aetna has demonstrated capability to produce reports in accordance with the State's Medicaid Fraud Control Unit (MFCU)'s standardized reporting template upon request, as referenced in **Appendix 5**. Our Special Investigations Unit and Compliance departments have successfully submitted four versions of the template to both BMS and MFCU.

Adherence to All State-Defined File Formats and Templates

MD018	The Vendor must adhere to all State-defined file formats and templates including, but not limited to, 834 enrollment and 837 encounter files.

On a weekly and monthly basis, Aetna successfully transfers files to and from the Department in accordance with State-defined file formats. These files are supported and are compatible with Aetna systems, and include the following:

- 837 encounter file (weekly); the 837-encounter file also includes vendor encounter information for both dental and vision benefits
- 834 enrollment file (monthly)
- 820 and 835 payment files (monthly)
- Encounter files will be submitted consistent with the National Council for Prescription Drug Programs, (NCPDP) D.0 communication standard; Aetna is not limited to the NCPDP D.0 standard and we will adhere to state-required formats as defined by the state (weekly)

Approval for All Key Staff Hired and All Personnel Assigned

MD019	The Vendor must obtain approval from the Department for all key staff hired under the contract and all personnel assigned to this contract. In all circumstances, key staff must be replaced only with persons of equal or greater experience and qualifications.

We are appropriately staffed to continue to manage this contract as we have been supporting our West Virginia Managed Care program for over 23 years; we will bring on additional resources as appropriate. We will obtain Department approval in hiring each key staff member hired under the contract and all personnel assigned to this contract. With each new key staff hire, we will ensure that new staff with equal or greater qualifications are hired through continual updating of job descriptions and qualification requirements as position responsibilities change and our operations progress.

Key Staff Assigned to the Project

MD020	The Vendor must employ Key Staff, defined as those responsible for providing leadership and creating the standards and processes required for the successful implementation, operation, and maintenance of the program, assigned to the project on a full-time basis. Each Key Staff role must be a full-time position, to be filled by one staff member only, unless otherwise approved by the Department. All Key Staff members must enter the project within thirty (30) calendar days of the contract award.

Key staff will be assigned to the project on a full-time basis. We will make certain that each key staff role will be full-time and filled by one specific staff member only, unless otherwise approved by the Department. We will ensure that we are operating the project at full capacity within 30 calendar days of the contract award with each staff member in place providing full service prior to contract start date.

Financial, Legal, Ethical, and All Other Forms of Responsibility

MD021	The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with the Vendor on the project.

We will continue to accept responsibility as required for financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting us or working with Aetna on the project. To create compliance with subcontractors, we have a system of subcontractor monitoring to bring extensive oversight to assist in selecting subcontractors and successfully monitoring and

overseeing their performance. These tools include initial and ongoing monitoring and pre-assessments, policies and procedures, and audits. We monitor our business partners, independent contractors, subcontractors, and other entities' processes through our vendor management systems with routine checks and audits of our subcontracted entities.

Drug-Free Workplace

MD022	The Vendor must provide a drug-free workplace for employees and all applicable agents including, but not limited to, subcontractors. All agents of the Vendor must not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract.

Aetna acknowledges, understands, and will continue to comply with the requirement to provide a drug-free workplace for its staff and all applicable agents, including but not limited to subcontractors. All personnel are expected to report to work free from the negative effects of drug or alcohol use and be able to fully perform their work duties. All personnel are screened as part of the pre-employment hiring process. We will make certain that all staff, agents, and subcontractors will not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract. We also provide an employee assistance program that provides services and supports regarding substance abuse. To assure compliance with this requirement for our subcontractors, we have a system of subcontractor monitoring to bring extensive oversight to their processes, including ensuring a safe and drug-free workplace and applicable provisions in subcontracting agreements.

Expenses Required to Access Department Systems

MD023	The Vendor must be responsible for all expenses required to obtain and maintain access to the Department systems. Such expenses include, but are not limited to, hardware, software, network infrastructure, and any licensing costs.

Aetna acknowledges, understands, and will continue to comply with the requirement to be responsible for all expenses required to obtain and maintain access to Department systems. We

understand these costs include but are not limited to hardware, software, network infrastructure, and any licensing costs.

Responsible for Costs Associated with Reports

MD024	The Vendor must be responsible for costs associated with reports requested and any action that involves the work of the State fiscal agent due to mock request or mock failure to meet State standards, as applicable.

Aetna acknowledges, understands, and will continue to be responsible for all costs associated with reports requested and any action that involves the work of the State fiscal agent due to mock request or mock failure to meet State standards, as applicable.

Results of Third-Party Audits

MD025	The Vendor must make available to the Department the results of any third-party audit conducted including, but not limited to, the Service Organization Control (SOC) 2, on the Vendor's organization.

Aetna acknowledges, understands, and will continue to comply with the requirement to make available to the Department the results of any third-party audit conducted, including but not limited to the Service Organization Control 2 on our organization. Aetna performs comprehensive penetration testing and vulnerability scanning, and we will upon request share numerous software security attestations such as security scorecard reports, penetration test reports, and BSIMM (Building Security in Maturity Model) assessments. Other assessments available include PCI HIPAA (Health Insurance Portability and Accountability Act), SIG (Standardized Information Gathering), SCA (Standardized Control Assessment), NIST (National Institute of Standards and Technology) 800-53, and CSF (Cyber Security Framework).

Authorization to Access Records

MD026	The Vendor must provide authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts to the Vendor's performance under the proposed contract.

Aetna acknowledges, understands, and will continue to comply with, the requirement to provide the Department access to our records. We currently routinely respond timely to requests from BMS for documents. In the event the Department determines that our relationship with a parent,

subsidiary of a parent, or an affiliate impacts our performance under the proposed contract, we will provide the Department authorization to have access to the applicable records.

Litigation Bond

MD027	The Purchasing Director reserves the right to require any Vendor that files a protest of an award to submit a litigation bond in the amount equal to one percent of the lowest bid submitted or $5,000, whichever is greater. The entire amount of the bond shall be forfeited if the hearing officer determines that the protest was filed for frivolous or improper purpose, including, but not limited to, the purpose of harassing, causing unnecessary delay, or needless expense for the Agency. All litigation bonds shall be made payable to the Purchasing Division. In lieu of a bond, the protester may submit a cashier's check or certified check payable to the Purchasing Division. Cashier's or certified checks will be deposited with and held by the State Treasurer's office. If it is determined that the protest has not been filed for frivolous or improper purpose, the bond or deposit shall be returned in its entirety.

Aetna acknowledges, understands, and will comply with the litigation bond requirements.

Meeting All Operational Requirements as Agreed Upon

MD028	The Vendor must have all requirements operational, as agreed upon with the Department, by July 1, 2020.

As an MCO within the State of West Virginia for over 23 years, Aetna will have all requirements operational, as agreed upon with the Department, by July 1, 2020. We develop a comprehensive work plan that incorporates the contract requirements to address all activities, work streams, and variables as part of our approach to a successful implementation. We use a multitiered approach to make sure that through transparency, integration, timely decision-making, and action execution, we deliver all implementation requirements from project initiation to operational performance—meeting all operational requirements at contract start date.

Primary Workplace in the State of West Virginia

MD029	The Vendor must maintain a primary workplace in the State of West Virginia.

As an active Medicaid MCO in West Virginia since 1996, we have had the vast majority of our staff residing in West Virginia for over 23 years. We are West Virginians continuing to maintain a primary workplace in the Mountain State. Our primary workplace in the State of West Virginia is located at 500 Virginia Street, East, Suite 400, Charleston, West Virginia 25301.

Mandatory Requirements		Vendor Response	
Req ID #	Requirement Text	Section	Page #
MD001	The Vendor must comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement (SPA) and any modifications pursuant to changes to State policy, State or federal laws and regulations, waiver amendments, or State Plan amendments.	Attachment 5 Mandatory Requirements - Compliance with Applicable Requirements	Att 5 - Page 1
MD002	The Vendor must comply with all Service Level Agreements (SLAs), as indicated in the Service Provider Agreement (SPA).	Attachment 5 Mandatory Requirements - Compliance with Applicable Requirements	Att 5 - Page 1
MD003	The Vendor must accept the rate established by the State on a per member per month (PMPM) basis for managed care physical health and behavioral health services.	Attachment 5 Mandatory Requirements - Acceptance of the Rate Established by the State	Att 5 - Page 2
MD004	The Vendor must establish a physical health and behavioral health provider network that provides adequate access, as defined by the Service Provider Agreement (SPA), and serves all counties in the State.	Attachment 5 Mandatory Requirements - Physical Health and Behavioral Health Provider Network	Att 5 - Page 2
MD005	The Vendor must submit its provider contract templates and addenda to the Department for approval.	Attachment 5 Mandatory Requirements - Submission of Provider Contract Template and Addenda	Att 5 - Page 2
MD006	The Vendor must submit an initial Value-Based Payment (VBP) plan to the Department and annually thereafter.	Attachment 5 Mandatory Requirements - Submission of Value-Based Payment (VBP) Plan	Att 5 - Page 2
MD007	The Vendor must be accredited by the National Committee for Quality Assurance (NCQA) no later than nine (9) months from its operational start date in the State.	Attachment 5 Mandatory Requirements - Accreditation by the National Committee for Quality Assurance	Att 5 - Page 2
MD008	The Vendor must provide all requested supporting documentation as specified by the Request for Proposal (RFP), and according to the requirements described in Section 3: General Terms and Conditions, as well as Appendix 4: List of Requested Documents.	Attachment 5 Mandatory Requirements - Requested Supporting Documentation	Att 5 - Page 3
MD009	The Vendor must provide twenty-four-hour access seven (7) calendar days a week to a provider or service in emergency situations.	Attachment 5 Mandatory Requirements - 24-hour Access to a Provider or Service in Emergency Situations	Att 5 - Page 3
MD010	The Vendor must monitor Primary Care Provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) and West Virginia Children's Health Insurance Program (WVCHIP) limits of members assigned per PCP.	Attachment 5 Mandatory Requirements - Monitoring Primary Care Provider Panels for Compliance	Att 5 - Page 3
MD011	The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA).	Attachment 5 Mandatory Requirements - Network Standards Documentation and Geographic Mapping Reports	Att 5 - Page 4
MD012	The Vendor must establish screening processes (per applicable federal and State requirements, as defined by the Department) designed to ensure that the Vendor does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal healthcare programs.	Attachment 5 Mandatory Requirements - Screening Processes	Att 5 - Page 4
MD013	The Vendor must participate in public meetings and other events at the request of the Department.	Attachment 5 Mandatory Requirements - Public Meetings and Other Events	Att 5 - Page 4

Mandatory Requirements		Vendor Response	
MD014	The Vendor must comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT), which can be found at the following links: http://www.wvdhhr.org/mis/policies.asp https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx http://www.state.wv.us/admin/purchase/privacy/default.html	Attachment 5 Mandatory Requirements - Current and Future Security Policies and Procedures	Att 5 - Page 5
MD015	The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.	Attachment 5 Mandatory Requirements - Compatibility with Versions and Standards	Att 5 - Page 5
MD016	The Vendor must ensure that the health information system accepts the Medical Assistance Identification (MAID) generated by the Department for all members for data collection and billing purposes.	Attachment 5 Mandatory Requirements - Accepting the Medical Assistance Identification	Att 5 - Page 6
MD017	The Vendor's information management system must have the capability to produce reports in accordance with the State's Medicaid Fraud Control Unit's (MFCU's) standardized reporting template upon request, as referenced in Appendix 5.	Attachment 5 Mandatory Requirements - Producing Reports in Accordance with Standardized Reporting Template	Att 5 - Page 6
MD018	The Vendor must adhere to all State-defined file formats and templates including, but not limited to, 834 enrollment and 837 encounter files.	Attachment 5 Mandatory Requirements - Adherence to All State-Defined File Formats and Templates	Att 5 - Page 6
MD019	The Vendor must obtain approval from the Department for all key staff hired under the contract and all personnel assigned to this contract. In all circumstances, key staff must be replaced only with persons of equal or greater experience and qualifications.	Attachment 5 Mandatory Requirements - Approval for All Key Staff Hired and All Personnel Assigned	Att 5 - Page 6
MD020	The Vendor must employ Key Staff, defined as those responsible for providing leadership and creating the standards and processes required for the successful implementation, operation, and maintenance of the program, assigned to the project on a full-time basis. Each Key Staff role must be a full-time position, to be filled by one staff member only, unless otherwise approved by the Department. All Key Staff members must enter the project within thirty (30) calendar days of the contract award.	Attachment 5 Mandatory Requirements - Key Staff Assigned to the Project	Att 5 - Page 7
MD021	The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with the Vendor on the project.	Attachment 5 Mandatory Requirements - Financial, Legal, Ethical, and All Other Forms of Responsibility	Att 5 - Page 7
MD022	The Vendor must provide a drug-free workplace for employees and all applicable agents including, but not limited to, subcontractors. All agents of the Vendor must not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract.	Attachment 5 Mandatory Requirements - Drug-Free Workplace	Att 5 - Page 8
MD023	The Vendor must be responsible for all expenses required to obtain and maintain access to the Department systems. Such expenses include, but are not limited to, hardware, software, network infrastructure, and any licensing costs.	Attachment 5 Mandatory Requirements - Expenses Required to Access Department Systems	Att 5 - Page 8
MD024	The Vendor must be responsible for costs associated with reports requested and any action that involves the work of the State fiscal agent due to mock request or mock failure to meet State standards, as applicable.	Attachment 5 Mandatory Requirements - Responsible for Costs Associated with Reports	Att 5 - Page 9
MD025	The Vendor must make available to the Department the results of any third-party audit conducted including, but not limited to, the Service Organization Control (SOC) 2, on the Vendor's organization.	Attachment 5 Mandatory Requirements - Results of Third-Party Audits	Att 5 - Page 9
MD026	The Vendor must provide authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts to the Vendor's performance under the proposed contract.	Attachment 5 Mandatory Requirements - Authorization to Access Records	Att 5 - Page 9

Mandatory Requirements		Vendor Response	
MD027	The Purchasing Director reserves the right to require any Vendor that files a protest of an award to submit a litigation bond in the amount equal to one percent of the lowest bid submitted or $5,000, whichever is greater. The entire amount of the bond shall be forfeited if the hearing officer determines that the protest was filed for frivolous or improper purpose, including, but not limited to, the purpose of harassing, causing unnecessary delay, or needless expense for the Agency. All litigation bonds shall be made payable to the Purchasing Division. In lieu of a bond, the protester may submit a cashier's check or certified check payable to the Purchasing Division. Cashier's or certified checks will be deposited with and held by the State Treasurer's office. If it is determined that the protest has not been filed for frivolous or improper purpose, the bond or deposit shall be returned in its entirety.	Attachment 5 Mandatory Requirements - Litigation Bond	Att 5 - Page 10
MD028	The Vendor must have all requirements operational, as agreed upon with the Department, by July 1, 2020.	Attachment 5 Mandatory Requirements - Meeting All Operational Requirements as Agreed Upon	Att 5 - Page 10
MD029	The Vendor must maintain a primary workplace in the State of West Virginia.	Attachment 5 Mandatory Requirements - Primary Workplace in the State of West Virginia	Att 5 - Page 10

2. Benefit Administration

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Benefit Administration (BA) as part of their bid. The Vendor's narrative response should not exceed 100 pages.

Aetna Better Health of West Virginia (Aetna) is honored to serve the State of West Virginia's most vulnerable populations through Mountain Health Trust (MHT) for over 23 years. In 2019, Aetna was the single managed care organization awarded the Mountain Health Promise (Specialized Managed Care for Children and Youth) business. We are dedicated to serving West Virginians, and we are prepared to expand our services to serve West Virginia Children's Health Insurance Program (WVCHIP) populations. We look forward to collaborating with the Bureau of Medical Services (BMS) and WVCHIP Agency to assist with the transformation of the system of care and services provided to both Medicaid and WVCHIP members through MHT in 2020.

Aetna's approach to benefit administration supports high-quality, whole-person care for all members by considering individual member needs and identifying and addressing potential disparities to accessing care. Our daily benefit administration processes and workflows integrate utilization management and care management functions as well as social needs to support holistic care. Aetna's coordinated comprehensive approach ensures members receive timely, appropriate care through individualized, innovative programs and coordination of services and community supports. We are continually evaluating opportunities to reduce administrative burden and to eliminate barriers to medically necessary medical and behavioral health services, while avoiding the provision of unnecessary or inappropriate care. Aetna staff at

all levels of the organization have the deep expertise and commitment essential to serving the populations included in this response through the full scope of work.

Our programs and systems are guided by a team of local experts who understand the resources and strategies needed to work collaboratively with communities and the Department of Health and Human Resources (the Department) to support all members in achieving their health goals.

We understand key populations, disparities, health indicators, areas of need for population health improvement, and regional differences because our **Care Connection teams** are local and reflect the diversity of the communities where our members live, work, and play. Regionally focused Utilization Management (UM) staff are vital members of the Care Connection teams serving those communities.

Aetna believes a comprehensive, holistic approach to benefit administration is best informed by utilization data that is reviewed in the context of national standards of care and an understanding of state-specific population health characteristics and regional environmental differences. This data allows us to identify and impact specific regional disparities in health outcomes facing West Virginians and provides broader insight into authorizing and administering benefits for our members statewide. For example, understanding key health data, such as prevalence of diabetes, behavioral health issues, deaths from drug overdoses, rates of adult smoking, teen births, availability of specialists, and current health outcomes including low birthweight provide valuable insight into developing action plans and policies to increase access to care and improve health outcomes.

Throughout this response, we will demonstrate Aetna's understanding of the complexity of managing utilization and care for Medicaid and WVCHIP members and illustrate how our

experience has prepared us to administer benefits to adults and children statewide as well as support communities to implement sustainable solutions. One example of a program developed through use of utilization management (UM) data is found in our work to address the devastating impact of opioid use disorder on our members.

Opioid Program Champion
Aetna's opioid program champion is a dedicated position responsible for supporting, communicating, and coordinating the goals and objectives of our opioid program and all care management opioid-related initiatives. Coordinating with other departments, the opioid champion serves as a point-of-contact for opioid-related care management projects, questions, news, and communication from Aetna's national leadership.

Combatting the opioid crisis in West Virginia:

Nationally, under the leadership of Don Gibbon, DO, the chief medical officer (CMO)/medical director of our Medicaid plan in West Virginia, Aetna Medicaid has implemented a multifaceted opioid strategy in West Virginia and 15 other states focusing on prevention, early intervention, and support for members. Aetna supports our providers and members through care coordination that meets members' needs in their home communities and facilitates continuity of care by reducing barriers to substance use disorder (SUD) treatment, including access to medication assisted treatment (MAT), support programs, and non-pharmaceutical alternatives to treat pain. Data from our opioid dashboard demonstrate that between January 2017 and August 2019, Aetna has achieved impressive results in addressing the opioid use crisis in West Virginia:

Aetna's CHIP Experience
Aetna's UM processes, staff education on clinical guidelines, provider education, trends identified through advanced reporting, and transition of care processes have facilitated successful administration of CHIP benefits in 12 states—experience we will leverage to enhance our existing West Virginia insight and knowledge to benefit WVCHIP members. Interventions used in other states have impressive results, including a 42 percent reduction in readmissions for CHIP members in Florida. Another initiative for members with attention deficit hyperactivity disorder (ADHD) resulted in an 18 percent increase in follow up visits.

- Rate of treatment with non-opioid procedures for members with chronic pain increased by 52.8 percent
- Rate of opioid prescription in members with a prior overdose decreased by 56.6 percent
- Rate of seven-or-more-day opioid prescription after an acute procedure decreased by 65.9 percent

In the following pages, we outline how our benefit administration policies, guidelines, and procedures support Aetna's whole-person approach to ensure our MHT, West Virginia Health Bridge (WVHB), and WVCHIP members can access timely, appropriate care. This response covers a broad spectrum of topics related to benefit administration as outlined in the State's request for proposal, including the following:

- UM guidelines and staff training
- Prior authorization
- Medical necessity
- Supporting continuity of care: in-network and out-of-network access
- Coordinating care: member reminders, behavioral health changes, dental coordination
- Family planning
- Crisis stabilization
- Early and Periodic Screening, Diagnosis, and Treatment Services
- Monitoring and tracking member co-pays and out-of-pocket maximums
- Fraud and abuse
- Pharmacy rebates

At the request of the Department, when responding to questions about the administration of pharmacy benefits, we have provided narrative addressing both carve-out and carve-in pharmacy scenarios throughout this response.

Utilization Management

BA004	The Vendor should describe its process for development and revision of Utilization Management (UM) guidelines, as indicated in the Service Provider Agreement (SPA).
BA005	The Vendor should provide its training curriculum for Utilization Management (UM) and clinical staff.
BA006	The Vendor should describe its Utilization Management (UM) monitoring guidelines that operate in conjunction with fraud and abuse detection activities, including, but not limited to, the following:
BA007	Ongoing monitoring of Emergency Room (ER) utilization
BA008	Ongoing monitoring of potential abuse of inappropriate utilization of controlled prescription medications

BA009 Reports and other tools that will be used to monitor and manage service utilization

Aetna's utilization management (UM) program's purpose is to deliver high-quality, whole-person care for our Medicaid and WVCHIP members by identifying, evaluating, managing, and improving clinical care and services. While managing utilization of services, the focus of UM is to promote delivery of high-quality and cost-effective care to our members by considering individual member characteristics, unmet health care needs, and disparities. Our guidelines conform to the requirements of the Model Purchase of Service Provider Agreement, Section 5.6, Utilization Management, and we will meet state-specified standards for service authorization identified in the contract.

Aetna Better Health of West Virginia's UM program is led by an exceptional clinical team of five West Virginian healthcare professionals. Dr. Gibbon is the CMO/medical director and leads Aetna Medicaid's national opioid initiative. Frank Angotti III, MD, the plan's behavioral health medical director, is a double-boarded psychiatrist and child psychiatrist. He sits on the WV Governor's Advisory Council on Substance Use Disorder. Kimi King, RN, is the medical management director and has 12 years' experience as the plan UM lead. Adam Breinig, DO, serves as a medical director and was the president of the WV State Medical Association and the WV Academy of Family Physicians. Wanda Hembree, MD, is an OB/GYN specialist who has expertise in neonatal abstinence syndrome and serves as a medical director.

The scope of our UM program spans all clinical aspects of physical and behavioral health, including preventive, diagnostic, dental, and treatment services in inpatient, outpatient, community, and home-based treatment settings. Our unique regionalized model features local Care Connection teams that include UM staff to address member and provider issues locally.

UM nurses are regionally assigned and develop relationships with providers and hospital groups to improve exchange of information and overall processes. Our providers have single points of contact for all UM and care management (CM) concerns or needs. UM and CM staff meet daily to collaborate on member needs. Our goal is to fully integrate our UM staff and Care Connection teams with all the tertiary care facilities to be available to providers locally as well as centrally.

Our UM program, under the direction of the CMO/medical director, is an integral component of our Quality Assessment and Performance Improvement program, which promotes continuous monitoring and evaluation of member care. The program aligns activities, such as quality outcomes and target goals, for value-based purchasing strategies.

With the understanding that provider demographics differ in each region of the state, the characteristics of the local delivery system and available resources are considered with each utilization request. Our local Community Connection teams know the providers serving their communities and assist members in finding providers. For example, in some parts of the state we have inpatient behavioral health facilities, but in other communities where these facilities are not available, Aetna local staff work with members to help them access facilities in other communities or find alternative care solutions in their community. In addition, all UM determinations are made by considering member characteristics such as age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment.

Although there are some differences in Medicaid and WVCHIP benefits, UM processes and criteria for WVCHIP are generally in alignment with Medicaid. We are adept at modifying our processes when necessary and will accommodate WVCHIP-specific criteria as appropriate to meet the requirements of the Model Purchase of Service Provider Agreement for Fiscal Year

2020. Our national experience makes training and implementation resources immediately available to our West Virginia staff.

[BA004] Developing and Revising Utilization Management Guidelines

Aetna uses nationally recognized, evidence-based criteria as UM guidelines, which we apply based on the needs of individual members, to align with the Department's clinical coverage policies outlined in the Model Purchase of Service Provider Agreement for Fiscal Year 2020. Our UM clinical criteria policies and procedures define eligible criteria sources and the processes for adoption, review, and approval of clinical criteria. Aetna regularly reviews our processes to develop and revise physical health and behavioral health service UM guidelines accordingly. We evaluate UM criteria by reviewing utilization, approvals and denials, and provider performance. In West Virginia, Aetna assesses all services provided to assure full parity of physical health and behavioral health (BH) services for Medicaid and WVCHIP members in compliance with the Mental Health Parity and Addiction Equity Act of 2008 through ongoing direct comparison of all medical and BH utilization and prior authorization (PA) requirements. We maintain a Mental Health Parity Compliance Plan, which is reviewed quarterly by our Services Improvement Committee and submitted to BMS annually.

Aetna reviews provider-specific approvals and denials to identify opportunities to streamline services for members and processes for providers by reducing the number of procedures requiring prior authorization. The Services Improvement Committee makes decisions on benefit changes identified in the parity analysis. Our licensed independent clinical social worker reviews BH utilization with the UM director and BH medical director, and their recommendations are forwarded to the CMO/medical director when warranted.

We review and update clinical criteria sets annually or as applicable when national or community evidence-based clinical criteria guidelines are released or revised. The annual review process involves a broad range of specialties such as emergency medicine, behavioral health, pediatrics, surgery, family medicine, internal medicine, and pharmacy to develop, adopt, and review criteria. Aetna ensures clinical criteria sets are sufficient to address the services necessary for diagnosis or treatment of illness or injury to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth and development. Aetna develops clinical criteria policies using peer-reviewed medical literature, regulatory action notices, technology assessments, 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.

Aetna uses the following medical review criteria for physical health (PH) and BH medical necessity decisions consulted in the order listed below:

- Criteria required by the Department or federal regulatory agency
- American Society of Addiction Medicine (ASAM)
- Milliman Care Guidelines (MCG) for physical and behavioral health criteria
- Level of Care Utilization System (LOCUS): BH services for adults
- Children and Adolescent Service Intensity Instrument (CASII): BH services for children
- Aetna Clinical Policy Bulletins
- Aetna Clinical Policy Council Review
- eviCore Healthcare Clinical Guidelines
- National Comprehensive Cancer Network Guidelines

Aetna's **Clinical Policy Council Committee**, made up of medical directors at the national level and external practicing clinicians with expertise in providing the types of services in the clinical criteria policies, conducts a comprehensive review process of both new and revised policies. This committee meets twice monthly and reviews changes to clinical review policies and reviews clinical literature to make sure we are congruent with national evidence-based clinical criteria.

We advise providers that criteria are available upon request in the notice of adverse benefit determination, and via provider webinars, email/fax blasts, face-to-face visits, and the provider manual in the provider portal. We advise members that criteria are available upon request and free of charge by contacting the Member Services department, in the notice of adverse benefit determination, and in the member handbook (available in print and through the member portal).

Aetna's lines of accountability strictly follow Department requirements and promote National Committee for Quality Assurance (NCQA) health plan standards for UM programs. Aetna's West Virginia and national UM leadership provide oversight of the UM program through the **UM Steering Committee**, including developing the UM program description and adopting PA codes. The **Quality Management/Utilization Management Committee (QM/UM Committee)**, made up of local providers and West Virginia Aetna leadership, provides governance, evaluates, and approves various reports. Additional insight is provided by the UM Resource Meeting, a group of UM and medical management leaders across Aetna nationally, who meet regularly in an informal forum to identify best practices and brainstorm new ideas. Aetna's board of directors has ultimate responsibility for oversight of the UM program, including adherence to program policies and procedures and review/approval of the annual UM program description and evaluation.

[BA005] Training for Utilization Management and Clinical Staff

Aetna employs highly qualified staff with clinical expertise and training to apply medical management criteria and practice guidelines. Individuals who conduct clinical utilization review are health professionals and possess West Virginia active relevant professional licenses. Staff conducting clinical reviews have access to consultation with our medical directors, who are licensed and board-certified physicians, 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. Aetna uses BMS' medical necessity definition for medical necessity determinations, and all determinations of medical necessity are made by qualified licensed and trained practitioners in accordance with state and federal regulations.

Aetna UM staff has expertise in physical and behavioral health, and waiver programs, as well as experience and training working with adults and children with disabilities and/or special health care needs. Staff receive training to combine clinical skills with service techniques to support Aetna UM processes, including PA, concurrent review, and retrospective review of services. Aetna staff participate in a broad variety of learning and performance activities on a regular basis, but no less than annually (please refer to **Table 6.2.1-2).** Only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease may issue service authorization and/or refer potential denials to a medical director. Our UM staff participate in a rigorous, comprehensive core training program that includes daily, monthly, quarterly, and annual ongoing training opportunities, as shown in **Table 6.2.1-1**.

Table 6.2.1-1: Core Training for UM Clinical and Non-clinical Staff

Training	Description/Modules	Clinical Staff	Non-clinical Staff
Core Welcome to Aetna	Introduction to Aetna's mission and core values	x	x
Core Utilization Management	Introduction to UM	x	x
	Receiving Service Requests	x	
	IP Census/Referrals/Identifying Issues During a Review	x	
	Processing Outpatient Requests	x	
	Processing Inpatient Requests	x	
	Defining Cultural Competency	x	x
	Broadening the Definition of Culture	x	

Training	Description/Modules	Clinical Staff	Non-clinical Staff
Core Cultural Competency 101	The Link Between Culture and Health	x	
	Culture and Healthcare	x	
Quarterly Cultural Conversations	Team discussions on assigned cultural competency topics	x	x
Trauma-informed Care	A 3-day training presented by the National Council for Behavioral Health in trauma, trauma-informed care, and its impact on our members	x	x
Core CMS	Medical Necessity Defined	x	
	Navigating CMS.gov	x	
	CMS Forms	x	
	Documentation and Practice	x	
Core MCG	Medical Necessity	x	
	Introduction to MCG	x	
	MCG Ambulatory Care	x	
	MCG Inpatient and Surgical Care	x	
	MCG General Recovery Guidelines	x	
	MCG Recovery Facility Care	x	
	MCG Home and Chronic Care	x	
	Aetna Clinical Bulletins	x	
	Learning Management System	x	
State Specific Materials	Sample modules: BH carved in benefit for medical management and required statement for member letters, Aetna Better Health of WV profile describing our plans and programs, populations served, footprint, benefits and services, value-added services, member costs, and prior authorization	x	x
Self-paced Learning Courses	EncoderPRO Vignettes: Encoder Pro is an online coding and reference tool	x	x
	IP Census Vignettes: IP Census is a web-based database that provides up to date information about members currently receiving inpatient care	x	

Training	Description/Modules	Clinical Staff	Non-clinical Staff
	Notice of Action (NOA) Database Vignettes: NOA system provides an automated method for generating and recording member and provider letters related to UM	x	x
	ProFAX Vignettes: ProFAX is a Medicaid enterprise-wide PA fax management web-based application for receiving, sending, and storing UM-related faxes	x	x
	QNXT Call Tracking: QNXT is a web-based system used to document communication with our members and providers	x	x
	QNXT Searching for a Member	x	x
	QNXT Searching for a Provider	x	x
	RxClaim Vignettes: RxClaim system can verify eligibility for drug coverage (if pharmacy is carved in)	x	x

UM Clinical Staff

Aetna's UM clinical staff utilize their clinical experience, criteria/guidelines, policies, and procedures to make timely and accurate medical necessity and benefit determinations. They review the member's specific clinical presentation and information to support authorization of requested services. UM clinical staff provide oversight to non-clinical staff to support quality care for our members. Our UM training curriculum prepares clinical staff in the consistent application of medical necessity criteria and minimizing denials, resulting in effective, efficient medical necessity determinations and compliance with requirements. UM supervisors are responsible for tracking the completion and accuracy of training by their staff. All courses are online, and individual completion is tracked and reviewed by supervisors.

UM clinical staff are assessed for competency immediately following the initial onboarding training period. After successfully passing the initial competency assessment, UM clinicians are assigned an

experienced mentor who provides on-the-job shadowing opportunities and additional orientation to ensure they are optimally prepared for their role. They also receive training annually on changes to review criteria. Clinicians have access to supervisors via instant messaging and readily accessible, online medical necessity criteria and policies and procedures when making review determinations. Our UM and Pharmacy teams, including medical directors, conduct quality chart review audits to assess consistency in medical necessity decision making and adherence to policies, procedures, and NCQA-based timeliness standards. Our UM team conducts quarterly quality chart audits with an internal goal to score 90 percent or above. If staff do not meet the goal, supervisors provide feedback and educate about related policies and procedures, regulations, and standards. An average review score less than the plan's benchmark requires development of a training plan and reassessment until demonstrated improvement occurs.

Aetna's UM initial and ongoing training timetable for clinical staff is outlined in **Table 6.2.1-2:**

Table 6.2.1-2: Timetable for UM Clinical Staff Training

Training	Timeframe	Training Curriculum
Initial Training	Weeks One and Two	Training on Aetna systems and mandatory staff training: compliance; Health Insurance Portability and Accountability Act (HIPAA); minimizing denials; and fraud, waste, and abuse; and clinical criteria guideline self-paced training and health plan contractual requirement training.
	Week Three	UM clinical staff shadow a mentor and review workflows, including denials and extensions, experiences application of clinical criteria; and self-paced training.
	Weeks Four and Five	UM clinical staff is assigned a limited number of cases, each reviewed by the mentor or the supervisor prior to processing; clinical criteria guideline self-paced training is completed by end of week five.
	Week Six, Seven, and Eight	Supervisor review with the mentor: collaboratively review chart audit findings, discuss forwarding denials to medical directors, communicating reasons for denials, peer-to-peer review, and appeal rights.

Training	Timeframe	Training Curriculum
	After Week Eight	Supervisor review of staff readiness for full caseload.
Program Training	Ongoing	Online training, which include processes to test ability to appropriately apply criteria; group training for all contractual or policy level change; for example, training on the International Classification of Diseases, 10th Edition (ICD-10) conversion; interdisciplinary case rounds to address consistency of applying criteria and to minimize denials.
	Daily	Question and answer sessions led by the UM team.
	Monthly	Management feedback on monthly audit reports on operational quality, including compliance with timeframes and adherence to policies and procedures (P&Ps).
	Quarterly	Management team to review utilization trends and regulatory changes; staff audits, quarterly compliance, and cultural diversity trainings.
	Annually	Management feedback on IRR results and case reviews to validate adherence to P&Ps.

Medical directors: Medicaid medical directors participate in a comprehensive orientation, education, and training program upon joining Aetna. The CMO is responsible for the development and individualized training curriculum for each medical director that includes, but is not limited to, the following:

- Health plan contractual requirements, plan benefit matrix, and medical necessity criteria
- Overview of quality, utilization, and care management programs with emphasis on specific activities for which the medical director will participate, including regionally specific UM trends and strategies for minimizing provider administrative burden and denials
- Plan benefit matrix
- Medical necessity criteria
- Process and requirements for chart assessments
- Process and requirements for Inter-rater Reliability (IRR)

In addition to the trainings for UM clinical staff outlined earlier, all medical directors who participate in the UM process also complete the Core Medical Directors Training, which includes the Medical Director's Role, Integrated Care Management, Tools and Systems, and Overview of the UM Process. Additional curricula include comprehensive training on the usage of clinical criteria.

Inter-rater reliability: The IRR test is a valuable process used to determine consistency in the application of medical necessity clinical guidelines and to identify educational opportunities. The use of MCG, LOCUS/CASII, ASAM, and Clinical Policy Bulletin criteria facilitates consistency and integrity in the process of making medical determinations. Uniformity in applying medical necessity criteria is essential in member satisfaction and compliance with the state and regulatory guidelines. We conduct annual IRR testing with clinical reviewers and medical directors. Our 2019 IRR results indicate a high level of understanding of UM processes and the application of nationally accepted medical necessity guidelines for both PH and BH services.

Inter-Rater Reliability Scores
Aetna's West Virginia staff scores exceeded the minimum compliance threshold of 85 percent with a **99.9 percent pass rate** for physical health case studies and a 98.85 percent pass rate for behavioral health case studies. Every individual score exceeded the 85 percent goal.

Physician review: Aetna's national Medicaid organization conducts quarterly audits of physician decision-making utilizing a tool that scores specific elements of the process. We audit initial determinations and appeals quarterly. Individuals not meeting the minimum criteria of 90 percent must complete a corrective action plan and receive further education.

[BA006] Utilization Management Guidelines Supporting Fraud and Abuse Detection

Aetna uses UM guidelines, policies, and data for **monitoring utilization** and **deviations from quality of care standards** as the foundation for fraud and abuse prevention and detection activities (please refer to additional detail about our fraud and abuse activities in **[BA010]** herein). At Aetna, preventing and detecting fraud and abuse is everyone's job. All staff are trained in detecting and preventing fraud, waste, and abuse (FWA), and staff are comfortable forwarding their concerns to the SIU, which is the hub for all FWA activities. Information

exchange between UM and SIU is key to ensuring vigilance in fraud and abuse detection. When appropriate, Aetna modifies our Medical Management policies to address emerging schemes and trends. Aetna processes and guidelines encompass three types of reviews:

- **Prospective review** includes the review of medical necessity for the performance of services or scheduled procedures. Prior authorization evaluation is based on state contract/manual requirements and then Milliman national standards and guidelines. PA processes detect and prevent FWA by setting guidelines and limits requiring medical necessity prior to services being performed.
  Concurrent review includes review of medical necessity decisions made while the member is currently in an acute, sub-acute (psychiatric residential treatment facility), rehabilitation, SUD residential, partial hospitalization (BH only), intensive outpatient, crisis stabilization unit, post-acute, and observation (out-of-network only) setting. Evaluation of decision-making in documentation reviews that use Aetna Clinical Policy Guidelines, long-term treatment plans and programs, and peer evaluation of treatment plans and protocols resulting in an eagle's-eye view of peer-to-peer outliers of treatment behaviors that can be considered FWA.
- **Retrospective review** involves a review of coverage after treatment is provided and data analysis of peer outliers across the network. This includes national schemes and trends.

Utilizing a multidisciplinary team approach, our Quality Management (QM), Provider Services, Pharmacy, and SIU departments work with the UM department to identify, track, and address over-utilization and under-utilization and to identify solutions and/or resolve FWA within the provider community. In utilization trend meetings, UM clinical staff look at patterns of usage for spikes to identify outliers in services, supplies, and prescription medications. The Aetna Medicaid organization identifies national

Medication Assisted Therapy

MAT for substance use disorder is complex. Treatment of pregnant patients with SUD adds another layer of complexity. The patient is identified as having a high-risk pregnancy since the newborn could develop neonatal abstinence syndrome after delivery. While using weekly urine drug screens for drug use is recommended for these patients, some providers were also administering weekly urine pregnancy tests at the same time. Ordering urine pregnancy tests for known pregnant patients—sometimes up to the week of their delivery date—was a clear indication of waste and abuse. The UM department is working with the SIU, who is developing a report identifying inappropriate urine pregnancy tests to recoup the cost.

trends in utilization, such as codes that are being abused in other states. In West Virginia, this information provides awareness of potential issues.

UM staff review data to identify potential **deviations from accepted standards of care** to determine if care complies with Aetna's standards of medical care and to ensure members are receiving appropriate and effective care. Data sources may include member complaints, such as inappropriate treatments or poor outcomes of care.

Our UM/QM Committee reviews West Virginia UM reports and dashboards weekly and monthly to identify trends and implement interventions. The clinical group of the FWA Committee reviews the UM reports and dashboards to identify provider patterns for potential fraud, waste, and abuse. On a quarterly basis, the SIU analytics group runs a minimum of 25 outlier reports of known categories of fraudulent schemes, such as up-coding, double billing, and billing for services that were not provided, based on specialty and current procedure terminology codes to identify the top providers of certain services. The medical management director, CMO/medical director, and BH medical director attend monthly meetings where these reports are discussed and broken out for further investigation. The CMO/medical director and SIU senior investigator meet monthly to discuss current cases and additional projects derived from the Code Team (an interdepartmental team of Operations and Medical Management staff which meets monthly to review code changes), UM analysis, and the SIU quarterly data mining.

Aetna's UM program includes processes, guidelines, review criteria, decision-making timeframes, and qualifications of health plan staff involved in UM processes. As an NCQA-accredited health plan with a 'Commendable' rating, we continually monitor our policies and

procedures for our UM processes through audits. We conduct an annual review of policies and procedures, which the Policy and Procedure Committee reviews and approves.

[BA007] Ongoing Monitoring of Emergency Room Utilization

Aetna's approach to monitoring emergency room (ER) utilization involves close collaboration between CM and UM staff and utilizes a variety of modalities, including near real-time data feeds and a geographic and demographic dashboard. We share ER utilization data through our population health information platform and work with providers through value-based purchasing agreements. We communicate ER visits with our internal service coordinators, home care providers, primary care providers, and specialty providers and work with hospitals to identify members with medium or high risk of returning to the ER so we can contact members during and after discharge to assess needs and create follow up plans.

Admission, discharge, and transfer feeds: We currently receive ADT feeds from PreManage via Collective Medical Technologies and the West Virginia Health Information Network into our population health platform and share the information with our providers in near real-time. We will continue to work with the state on clinically integrating data to reduce barriers for our members.

Demographic distribution for ER utilization dashboard: This dashboard allows Aetna staff to monitor ER utilization data through demographic and health equity lenses. The dashboard sorts and filters member ER utilization data to identify possible demographic-related disparities related to race, ethnicity, language, geography, or adverse incidents. We map where high ER utilizers reside, which allows us to assess local hospitals, urgent care centers, and providers with after-hours care to assist members with finding appropriate, available services when possible. This provides for a region-specific, targeted approach to ER diversion through data identification and clarification of existing inequities.

[BA008] Ongoing Monitoring of Inappropriate Utilization of Controlled Prescription Medications

Aetna's drug utilization review (DUR) approach to managing inappropriate utilization of controlled prescription medications is consistent with 42 CFR 438.3(s)(4) and (5), and requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K. Our collaborative and integrated member-centered approach to DUR programs promotes appropriate medication use with special focus on controlled prescription medications. Our approach decreases fragmentation and increases integration across providers and care settings thus minimizing unsafe medication use. Programs led by our pharmacy director under the guidance of our CMO/medical director foster collaboration among community-based retail pharmacists and Aetna CM and Medical Services teams when working with members identified with DUR opportunities. Aetna delivers DUR programs structured to ensure outcomes measurement to our West Virginia members, providers, and the State.

A Team Approach

A prior authorization nurse reviewing urine drug screen requests noticed an overutilization pattern, which she presented to our SIU. A review of medical notes accompanying the PA requests by Aetna's medical director uncovered an abnormal prescribing pattern. Using the Prescription Drug Monitoring Program (PDMP), our pharmacy director discovered a provider was prescribing Suboxone® and a benzodiazepine together, which is prohibited by the WV pharmacy preferred drug list criteria because the combination is potentially lethal.

Members were using Medicaid to pay for Suboxone® and paying cash to the pharmacy for the benzodiazepine prescription, which was documented in the PDMP reports. Aetna's BH medical director and pharmacy director's reviews confirmed our concerns.

Aetna opened an investigation in late 2019, which included information from another provider suggesting members were leaving her practice because of the other practice's willingness to write benzodiazepine prescriptions. We are researching further with the WV Office of Program Integrity, who will determine recommendations and next steps to the WV Medicaid Fraud Control Unit and/or the WV Board of Pharmacy for review.

In **Table 6.2.1-3** we have noted a sampling of controlled medication reports used to monitor and analyze utilization patterns and trends providing detailed claims information and comparative

data points. These reports, created using pharmacy claims from West Virginia, are generated and used on daily, weekly, monthly, and quarterly bases.

Table 6.2.1-3: Controlled Prescription Medication Reports

Report	Description
Controlled Substance High Utilizer	Members with 10 or more prescriptions in 30 days, or members with 3 or more prescribers in 30 days
Opioid High Utilizer	Members filling 10 or more opioid prescriptions from 4 or more prescribers filled at 4 or more pharmacies in the date range specified
Controlled Substance Activity	Members filling or attempting to fill prescriptions for stimulants, narcotic antagonists, opioid dependence medications (e.g., Suboxone), and opioids
Top Prescriber of Controlled Substances	Providers with highest activity by controlled substance drug cost and number of controlled substance prescriptions
Prescriber Abuse	Providers overprescribing or exceeding cumulative quantity limits for controlled substance
Pregnancy – Opioids	Pregnant members filling opioid and/or Suboxone
Multiple Controlled Substances	Members filling prescriptions for controlled substances in multiple drug categories, for example, stimulants and benzodiazepines, opioids and benzodiazepines, opioids and skeletal muscle relaxants, and opioids or stimulants and gabapentin as well as other controlled substance combinations

In addition to the reports above, Aetna's clinical pharmacy staff, using information on medication use and prescribing from multiple sources, including the PDMP, works closely with our CM and QM departments to exchange ideas to improve member and provider access and use of medications. When faced with a challenge, such as misuse of controlled substances, we convene our interdisciplinary team to identify and implement solutions.

If BMS determines the pharmacy benefit should be carved into services provided by Aetna, we can deploy additional tools and resources to monitor and act on inappropriate use of controlled substances. In collaboration with our pharmacy benefit manager (PBM), CaremarkPCS Health,

we would utilize our pharmacy point of service claims adjudication system's Prospective Drug Utilization Review (ProDUR) alerts and safety edits to identify unsafe prescribing and prescription filling behaviors by implementing edits that alert the pharmacist to unsafe medication use. Triggered pharmacy claim edits will send messages to pharmacists and request action by the pharmacist and/or prescriber. Examples of edits include controlled substance high dose or high quantity, duplicate therapy, unsafe drug combinations (opioids and benzodiazepines), and high cumulative opioid morphine equivalent daily dose. Aetna also has the ability to implement member-specific controlled substance edits when our integrated care team determines a member's safe medication use requires assignment to a specific prescriber and our pharmacy. Members selected for assignment are managed by an Aetna care manager who works closely with the member and their medical and pharmacy providers. Additionally, Aetna could utilize reports (e.g., early refill attempts for controlled substances) generated by our PBM's reporting platform to identify and take action on inappropriate use of controlled substances; these reports would supplement reports we currently create and utilize.

Targeted interventions: Aetna's written policies and procedures help establish consistency in the processes we use to detect the inappropriate use of controlled substance medications by our Medicaid and WVCHIP members. Aetna applies our DUR tools to assess member and provider opioid utilization patterns and drive development and implementation of interventions and educational programs. Interventions include, but are not limited to, the following:

- Our pharmacists and care managers identify members whose use of opioids may not be appropriate for their conditions and reach out to the member's prescribing providers to alert them of our findings and create a plan of care.
- Our pharmacy analytics team identifies outlier prescribers with algorithms matching national drug code, primary and secondary diagnosis, and place of service to support identification of use of opioid medications by our members. If a prescriber is identified with abnormal or problematic prescribing patterns, we refer the situation to the State's pharmacy director.

- Care managers coordinate medication reconciliation for members in moderate and high-risk levels and provide education on side effects and proper use promoting alternative medications or strategies to relieve pain versus opioid medications.
- The Patient Utilization Management and Safety Committee evaluates identified members' utilization to determine whether they are candidates for prescriber assignment. When the pharmacy benefit is carved in, Aetna has the ability to assign a member to a specific pharmacy, prescriber, and/or specific emergency provider for their medications.
- Quality of care referrals for outlier prescribers are submitted by our CM, UM, DUR, and Grievance and Appeals teams. Our CMO/medical director, pharmacy director, or a clinical pharmacist contacts the identified practitioner to review their prescribing patterns. The outreach focuses on reviewing results and educating on appropriate prescribing practices. Information from this interaction is brought to our QM/UM Committee for review and action, including corrective action plans, claims denial, or termination from the network.
- Aetna's SIU reviews cases of outlier prescribing to identify potential FWA by members and providers. The SIU recovers identified overpayments and refers cases to the Health and Human Resources Office of Inspector General for further investigation/potential sanctions.

If the pharmacy benefit is carved into managed care organization (MCO) services, we can utilize additional resources and tools provided by our PBM, CaremarkPCS Health, to monitor for and take action on instances of inappropriate use of controlled substances. The Aetna Pharmacy team could work with our PBM, who manages the pharmacy network and conducts claims review and pharmacy audits to prevent, detect, and act on inappropriate use of controlled substances by pharmacies, members, and prescribers. CaremarkPCS Health performs paid drug claims reviews for all pharmacies in our network and performs rejected claims review using targeting logic built to validate accurate clinical adjudication. If an issue is detected, the team escalates the issue to ensure expedient remediation and the safety of our members.

To identify potential member safety issues due to the inappropriate utilization of controlled substances, Aetna will use CaremarkPCS Health's Retrospective Safety and Monitoring program that employs staff pharmacists to review and intervene on claims reports generated daily, monthly, and quarterly. This program identifies, corrects, and/or deters potential cases of overutilization at the member and provider level for high-abuse drugs. It targets high-risk drug

classes such as opioids, benzodiazepines, muscle relaxants, and stimulants in addition to inappropriate use related indicators such as multiple drugs, provider shopping, and high-total controlled substance claims volume. The unique risk score stratification prioritizes interventions, and claims are screened according to preset edit criteria. Based on these criteria, a risk score is calculated, and cases are created for pharmacist review and intervention, which includes a letter to the prescriber and/or pharmacy and continual follow up and monitoring. Additionally, on a quarterly basis, clinical pharmacists evaluate controlled substance claims and supporting medical data to identify potential medication misuse for intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity, and potentially inappropriate situations are referred to our pharmacy director, a care manager, or Aetna's SIU.

[BA009] Monitoring and Managing Service Utilization

Aetna uses utilization and gaps in care data, inpatient alerts, and value-based purchasing contracts to monitor and manage service utilization and detect and prevent fraud and abuse. Onsite UM staff at high-volume provider sites review gaps in care, meet with members, assist in discharge planning, identify barriers (including transportation) and individual circumstances, and offer a warm transfer to CM services to members needing ongoing follow-up or further resources. Inpatient cases are discussed in UM/CM rounds with medical directors daily. In monitoring and reviewing claims, UM staff identify outliers and discrepancies between claims and authorizations or abnormal patterns of utilization. Quality staff focusing on Healthcare Effectiveness Data and Information Set (HEDIS®) measures in chart reviews identify over-utilization and under-utilization and refer those issues to UM for further research and follow up. Potential fraud and abuse issues can also be uncovered in regional daily rounds in which UM and CM staff participate.

UM Performance Dashboards: We use a suite of UM dashboards to identify high utilizers and engage care managers for immediate intervention. Dashboards include the following measures:

- Readmissions (please refer to **Figure 6.2.1-1**)
- Observations vs. one- to two-day stays
- ER utilization by facility, level billed, and primary system chief complaint
- Neonatal intensive care unit admission patterns
- Medical claims trends
- Outpatient authorization trends
- Inpatient performance to target trends

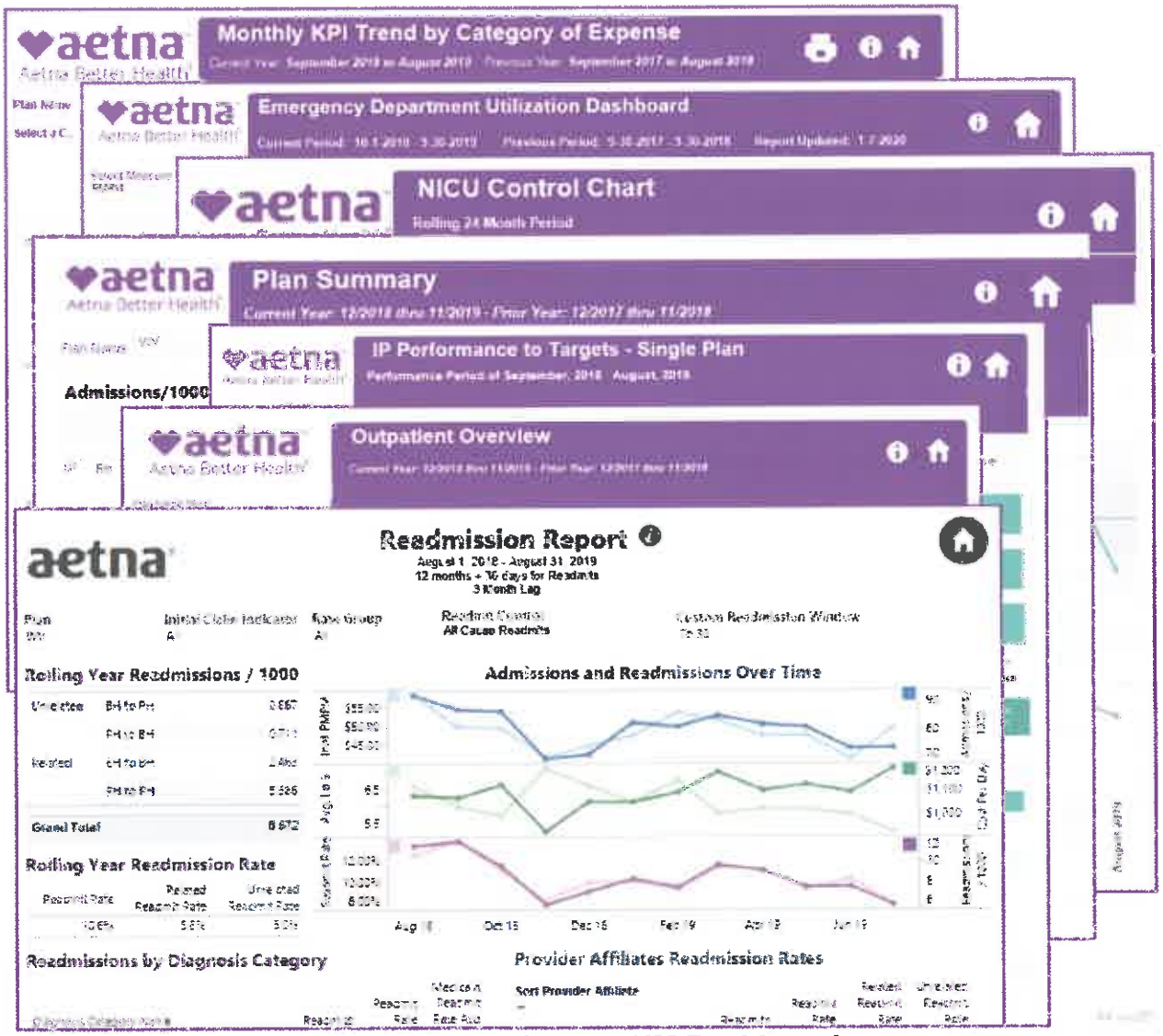


Figure 6.2.1-1: Sample UM Dashboards

Aetna uses near real-time UM dashboards to monitor utilization data to identify opportunities to take timely actions to improve provider and member experience.

Gaps in care reporting: We utilize gaps in care reporting internally and externally to address under-utilized services. This allows us the opportunity to encourage needed care such as screenings, well visits, and follow-up care and help the member get to the appointment. Based on the gaps in care report and indication of under-utilization, we look at primary care provider (PCP) assignment, high ER utilization, and readmission rates to determine if a member needs specific outreach or resources in completing care. We have been utilizing gaps in care reporting since 2015 with our value-based purchasing (VBP) collaborators and have seen a positive impact on our compliance rates for HEDIS measures such as diabetes, immunization, and screenings, as well as decreased ER utilization and readmission rates. We also share gaps-in-care reports with our providers and work with them to assess member needs in closing those gaps. Our team (CMO/medical director, medical director, health services director/manager, network account manager, and clinical pharmacy advisor) meet onsite with providers to discuss ways to encourage members' adherence to treatment and explore alternatives to inpatient admissions.

Value-based purchasing: Aetna has an established alternative payment model (APM) program in West Virginia affecting 21 percent of our membership today. Our current APM options include pay-for-quality, shared risk, shared savings, and capitation. From physician incentive plans with patient-centered medical homes/advanced medical homes to shared risk and then to full-risk capitation, we work with our value-based purchasing providers on their areas of focus using data from UM dashboards. As providers move along the APM value continuum, we link incentives to improved quality, reduced costs, and increased member satisfaction and engagement. One of our value-based purchasing collaborators, Marshall Health, identified

utilization concerns, and we are actively collaborating with them around ER rates and reviewing their ER dashboards to determine if the ER visits could be addressed in primary care settings. We are working with them to review the data, assess for any root causes, and identify appropriate interventions. Already we have seen a trending decrease in ER visits.

Utilization Management for Members with Special Health Care Needs	
BA011	The Vendor should describe its process for modifying its standard Utilization Management (UM) protocols when reviewing referral and treatment requests for members with special health care needs, including, but not limited to, the following:
BA012	Standing referrals
BA013	Expedited utilization review processes
BA014	The Vendor should describe its process for any condition-specific protocols or standards that will be used to manage members with special health care needs, defined as individuals with complex or serious medical conditions
BA015	The Vendor should describe its process for how condition-specific protocols and conditions will be updated and shared with primary and specialty care providers

Aetna recognizes the need for flexibility and care when managing services for individuals with complex or serious medical conditions and modifies our UM protocols accordingly to ensure our members receive the care they need in a timely manner.

[BA011] Modifying Utilization Management Protocols for Members with Special Health Care Needs

Aetna modifies our standard UM protocols to reduce provider burden and avoid delays for members when reviewing referral and treatment requests for members with special health care needs (individuals with complex or serious medical conditions). Examples of factors that may require modification include the following:

- **Benefit limits:**
  - **Lifetime benefit:** e.g., for members in need of orthopedic braces due to scoliosis or spina bifida, exceptions can be made for new braces as the child grows
  - **Benefit exceptions for therapeutic services:** e.g., for members with developmental delays in need of physical therapy, occupational therapy, or speech therapy, Aetna makes exceptions to benefit limits for therapeutic services, such as allowing additional physical

therapy treatments past the benefit limit for the treatment of an acute injury or chronic pain condition when medically necessary, or allowing additional urinary catheters beyond the benefit limit when medically necessary

- **Time limit exceptions:** e.g., for members in the course of ongoing treatment, Aetna makes exceptions to time limits during the transition phase to make sure treatment is completed
- **Place of service exceptions:** e.g., for members with mobility limitations, Aetna makes exceptions to place of service requirements to allow for services to be provided in the home
- **Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT):** e.g., any service requested under EPSDT that is not otherwise covered as a Medicaid benefit can be covered when it meets EPSDT criteria
- **Medical foods:** e.g., for members with feeding difficulties who require special medical foods otherwise not covered through Women, Infants, and Children (WIC) benefits, Aetna makes exceptions to assure nutritional needs are met

[BA012] Standing referrals: Aetna members who require specialized care over a prolonged period for life-threatening, degenerative, or disabling conditions may be allowed a standing referral to a specialist or specialty care treatment centers with expertise in treating their condition or disease. This includes conditions with a complicated treatment regimen requiring ongoing monitoring of the member's adherence, such as rheumatology or neurology, and BH services for members with a history of trauma or adverse childhood experiences.

The determination and notifications must be made within the timeframes appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed seven calendar days from the receipt of the request. If clinical information is not sufficient to determine medical necessity, UM staff make multiple attempts to obtain needed information to ensure the appropriate decision is made without delay. The process includes authorizing requests for standing referrals for members requiring more than one visit to a specialist or specialty care center for treatment of a condition. Aetna care coordinators and UM staff research a member's authorization history to avoid duplicating services the member is currently receiving or

authorizations already documented in the system and authorizing services that are not in the member's benefit or treatment plan.

[BA013] Expedited utilization review processes: Prior authorization enables us to monitor utilization of defined services and procedures and non-emergent hospitalizations before the member receives the service. For services requiring PA, we confirm services as follows:

- Requested for eligible members
- Included in the covered benefits
- Provided at an appropriate level of care or place of service to meet the member's needs
- Appropriate, timely, and cost-effective to best meet the member's needs
- Coordinated as necessary with quality management or care management, and information is communicated to applicable operations areas (e.g., Finance, Enrollee Services, and Provider Services) or per contractual requirement with external contractors
- Accurately documented to facilitate timely reimbursement and accurate reporting

At any point in the UM processes (e.g., PA, concurrent review) a member or a provider acting on the member's behalf may request an expedited review if a delay in the decision could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. **We make an expedited authorization decision as quickly as clinically needed given the member's health condition and provide notice no later than 48 hours after receipt of the request for service.**

[BA014] Condition-specific Protocols or Standards for Members with Special Health Care Needs

Aetna provides specialized medical care for children and adult members who have or might have a chronic, disabling medical condition(s). On a monthly basis, Aetna care coordinators reach out to members who have special health care needs to inform them of Aetna's Specialty Care Program, which provides care management and access to specialty services through a system of outreach specialty clinics. Members identified with special health care needs are

referred to providers who have the training to meet the individual member's unique needs. The program enables members with special health care needs to receive a patient-centered medical home approach to comprehensive, coordinated services, and supports including the local Care Connection teams and needed community resources. The Aetna care team remains the single-point of contact guiding the member's choices in his or her journey.

Pregnancy and HIV

Julie[1], a 36-year-old newly pregnant member, was advised that she was HIV positive early in her pregnancy. Aetna's care manager, who was embedded at a high-risk OB clinic, met with Julie immediately following her diagnosis to help relieve her panic and concerns. The care manager spent time with Julie discussing her options and helping her understand HIV treatment, terminology, and preventing infection of others.

Aetna's care manager coordinated care essential for Julie to deliver a healthy baby and manage her HIV. After referring Julie to an infectious disease specialist for HIV treatment, our case manager continued to see Julie regularly during her prenatal visits at the OB clinic, helping Julie understand how to manage pregnancy and HIV simultaneously, resolve issues with her boyfriend, and apply for income assistance to facilitate financial stability.

Julie delivered a healthy baby girl, who has so far tested negative for HIV. Julie is established in HIV treatment and is aware that HIV is a lifelong condition she will be able to manage with regular care and medication.

Eligible medical conditions for members with special health care needs include, but are not limited to, the following:

- Conditions of bones, joints, or muscles
- Heart conditions
- Epilepsy and other convulsive conditions
- Neurological conditions such as cerebral palsy and spina bifida
- Neonatal abstinence syndrome
- Organ transplants
- Human immunodeficiency viruses
- Hemophilia
- Certain operable eye conditions, such as crossed eyes and congenital cataracts
- Kidney and urological conditions, including those requiring dialysis
- Cleft lip/palate and other conditions requiring treatment by an otolaryngologist
- Ear, nose, and throat conditions requiring treatment by an otolaryngologist

[1] Not her real name

- Hearing loss, including hearing aid placement, and related services
- Other chronic conditions, such as cystic fibrosis, and sickle cell anemia

Most children with special health care needs receive high-risk intensive care management with frequent face-to-face meetings at enrollment and quarterly thereafter, comprehensive bio-psychological assessment, condition-specific assessments, integrated care and service planning, chronic condition management provided by a clinician, monthly member contact and care plan reviews, annual re-assessments based on member needs and indicated by changes in condition, and complex care coordination. Aetna conducts collaborative activities with family-centered, community-based systems of coordinated care for children with special health care needs, including early intervention and screening, linkage with parent support groups and forums, and adolescent pregnancy prevention programs. We collaborate with the Office of Maternal, Child and Family Health (OMCFH) to improve members' sense of safety, enhance the member experience and access to services, coordinate care through the sharing of care plans, and reduce barriers to achieving health goals. Currently, we attend a monthly meeting with OMCFH to discuss strategies to remove or mitigate service barriers for individual children with special health care needs.

[BA015] Developing, Updating, and Sharing Condition-specific Protocols or Standards with Providers

Condition-specific protocols and standards are reviewed at least annually by our local QM/UM Committee and nationally by the Aetna Clinical Council Policy Committee. When a protocol or standard is substantially changed, our internal policy and criteria change as well. If this change occurs prior to the annual review, it is presented sooner. These changes are brought to our QM/UM Committee for review and approval. Updated information is communicated to our

providers through electronic notification and posting on our website. Examples of condition-specific protocols and standards adopted by Aetna include, but are not limited to, the following:

- National Heart, Lung and Blood Institute- Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report
- American Academy of Pediatrics Diagnosis, Evaluation and Treatment of ADHD in Children and Adolescents
- American Diabetes Association Standards of Medical Care in Diabetes
- U.S. Department of Health and Human Services Clinical Guidelines for Treatment of HIV/AIDS
- Centers for Disease Control & Prevention Cessation Materials for State Tobacco Control Programs, multiple guidelines
- Centers for Disease Control & Prevention Guideline for Prescribing Opioids for Chronic Pain
- American College of Cardiology Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults

Prior Authorization

BA016	The Vendor should describe its process to honor authorization approvals from previous coverage during the transition period, defined as the period in which members are moving from one Managed Care Organization (MCO) to another, or from Fee-For-Service (FFS) to an MCO, or private insurance to an MCO. These processes should include, but are not limited to, the following:
BA017	Medical services (includes Physical, Behavioral Health, Dental, and Vision)
BA018	Pharmacy
BA019	The Vendor should describe how providers and/or members will be notified regarding the expiration of medical authorizations, and pharmacy authorizations, if applicable.

Aetna's member transition process works to ensure members' care continues without interruption or delay during the transition of moving from one MCO to another, from fee-for-service to an MCO, or from private insurance to an MCO. In alignment with the requirements set forth in the Model Purchase of Service Provider Agreement for Fiscal Year 2020, Section 5.4.6, Transition of Care, Aetna will honor authorization approvals from previous coverage during the member's transition period from another MCO, fee-for-service plan, or private insurance for medical and pharmacy services, in accordance with our transition of care policy and PA guidelines for Medicaid and in adherence to WVCHIP guidelines for WVCHIP members.

[BA016] Honoring Authorization Approvals from Previous Coverage During Transitions

Aetna will honor authorizations from Medicaid and WVCHIP members to maintain continuity and quality of care and services during the transition after enrolling in our plan. We understand some WVCHIP members may experience challenges in moving from fee-for-service to managed care. All WVCHIP members will receive a welcome packet and a welcome call. During the call, they are given the opportunity to transfer to a Member Services representative to answer any questions they may have. WVCHIP members will also receive an automated outreach call to complete a health risk questionnaire with the opportunity to request a call back from Aetna staff or immediate transfer if responses indicate that level of urgency. We ensure our member-facing staff are well informed on WVCHIP benefits and regulations so they can assist these members in understanding and adjusting to processes around member concerns, provider selection, PA, or any information which may be unfamiliar to them.

[BA017] Physical, Behavioral Health, Dental, and Vision Services: Aetna's standard transition of care procedures include honoring existing medical and BH authorizations for 90 days, or until the current treatment is completed (e.g., supporting a

Continuing Care in Therapy

Jimmy[2], a nine-year-old member with generalized anxiety disorder, was afraid to go to school because he was worried something would happen to his mother, who has a brain tumor. Working with horses as part of his therapy has helped Jimmy cope with his anxiety. The therapist providing the therapy with horses was not an Aetna network provider, and the closest provider having similar services is more than an hour away from Jimmy's home.

Our prior authorization nurse advocated on Jimmy's behalf and secured authorization for continued services. We are now working with the therapist to join the Aetna network, providing another valuable behavioral health provider resource for our Medicaid members in Marlinton.

[2] Not his real name

pregnant mother through the delivery of her child or a member in treatment for cancer) to assure continuity of care and honoring previously established therapeutic relationships for our members. Our local staff are focused on our members and providers and the quality of their experience with us. When Medicaid and WVCHIP members transition to Aetna from another MCO, private insurance, or fee-for-service, they are identified by a rate code or otherwise flagged in our informatics system. This allows UM staff to identify current authorized services that should be continued during the transition period to support continuity of care. In addition, the Claims Processing department uses rate code information to assure claims received during the transition period are paid timely and correctly without an Aetna PA via our electronic claims management system.

[BA018] Pharmacy: Aetna supports Medicaid and WVCHIP member transition from previous coverage by providing access or ensuring access to covered medications consistent with state requirements by ensuring availability of two fills of a medication up to a 34-day total transition supply within 90 days from the date the member becomes eligible with Aetna. When the pharmacy benefit was carved in prior to July 1, 2017, most of the transition medications adjudicated by Aetna were for non-formulary maintenance medications or any formulary medications that have a prior authorization or step therapy requirement, and excluded Suboxone®/Subutex, statutory excluded medications, and specialty medications. Additionally, Aetna ensured that members received letters from CaremarkPCS Health about the transition fill medication, expiration of transition coverage, and the needed next steps to ensure continuity of care. A copy of the member transition letter with instructions for action was sent to prescribing provider each time the member received a transitional fill. Letters to members and prescribers were sent within 24 hours of transition fill.

Aetna ensures continuity of care for new members on protected medications, such as immunosuppressants for organ transplant, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, anti-neoplastics, and BH medications by providing access to the medication as long as the prescriber writes for the medication. For members stabilized on any medication during an inpatient hospital stay, Aetna ensures access to the medication if medically necessary as determined by the prescriber's written prescription and plan of therapy. Aetna understands each member's experience is unique, and we work directly with our members to assure their medications and treatments are not interrupted with any of their transitions.

[BA019] Notifying Members and Providers when Medical and Pharmacy Authorizations Expire

The original service authorization notification sent to providers clearly outlines the duration of all authorized services and outpatient prescription drug products, and thereby provides advance notice of authorization expiration dates. In the rare occasions when the authorization is terminated before the original expiration because of new information that makes the previously authorized service or product no longer medically necessary or clinically appropriate for the member, Aetna will send an electronic/written NOA to member and providers informing them of the status change. The notification includes information on how to obtain criteria used to make the decision as well as member appeal rights and provider appeal rights. Our NOA process complies with 42 CFR 438.404, including timeframes for notice and notice contents. Following an initial decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, we send written notice to the member and provider. Our notice is on the Department-required template, is thoroughly completed in easily understandable language, and includes all required information detailed in 42 CFR 431.210.

Medical Necessity

BA038	The Vendor should describe its policies and procedures that outline how cases of medical necessity will be handled when medical service limitations are imposed.
BA039	The Vendor should describe its policies and procedures that outline how cases of medical necessity will be handled when prescription limits are imposed.

We adopt evidence-based clinical practice guidelines from nationally recognized sources to promote consistent application of evidence-based treatment methodologies, facilitate improvement of health care, and reduce unnecessary variations in care. Our processes conform to the Model Purchase of Service Provider Agreement for Fiscal Year 2020, Section 5.4, Service Authorization (Prior Authorization) requirements. Aetna uses the following criteria determining medical necessity for authorization of physical health, behavioral health, dental, vision, and pharmacy services (please refer to clinical criteria guidelines listed to **[BA004]**) herein).

Aetna's standard prior authorization process: Aetna receives PA requests from the member's provider by phone, fax, or provider portal. The request is reviewed to determine if the member is actively enrolled with Aetna and does not have other insurance, if the provider is in our network, if the service is a covered benefit, and if the service requires an authorization. When clinical information has not been provided, we request it from the provider. To ensure timely access for our members, PA requests are prioritized based on urgency. Any request that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of a practitioner with knowledge of the member's medical condition would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request, will be treated as an urgent request. The determination of whether a service is medically necessary is made on a case-by-case basis, considering the needs of the member and allowing for consultation with requesting providers

when appropriate. When a clinical review is in order, a nurse clinician reviews the request specific to the member's needs, including the following:

- Appropriateness of proposed service/treatment (service history)
- Past treatment
- Physicians treatment plan
- Age
- Co-morbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Review characteristics of the delivery system for availability of services in the area to support the member
- Practitioner/facility ability to provide all recommended services

Once medical necessity criteria are met, we notify the requesting provider and the member's assigned care manager, as appropriate. Certain medically necessary medical services may exceed established coverage guidelines. In these circumstances, coverage determination is based on Aetna UM alternative procedures, such as referral to a licensed physician with the appropriate clinical expertise for review.

[BA038] Policies and Procedures for Medical Necessity with Medical Service Limitations
Consistent with Aetna West Virginia Policy, 7100.05, Prior Authorization, and Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria and Fee for Service Medicaid provider manuals on the West Virginia Department of Health and Human Resources website, Aetna conducts medical necessity reviews when medical service limitations are imposed. Medical directors use formal criteria to support the clinical review of continuing services beyond the benefit limitation. Determinations of medical necessity are made by qualified and trained practitioners in accordance with state and federal regulations, and only a medical director can reduce or deny a request for services beyond set limits based on a medical necessity review. The medical director reviews the request, the member's need, and clinical information. Using the approved criteria and medical director's clinical judgment, a determination is made to

approve, deny, or reduce the service. If the reviewing medical director determines that applicable medical necessity criteria are not clear or application of criteria to this situation is in question, the medical director may submit a request to the Aetna Clinical Policy Council, which will research applicable literature and respond to the medical director with a determination.

The medical director may contact the requester to discuss the case or consult with a board-certified physician from an appropriate specialty area before determining medical necessity. All medical director discussions and actions, including discussions between medical directors and treating practitioners or providers, are documented in our authorization system.

Throughout the process and after the determination, Aetna medical directors conducting clinical reviews are available to discuss determinations with attending physicians or other ordering providers via peer-to-peer consultations for any request that may result or has resulted in denied authorization. If a peer-to-peer conversation or review of additional information does not result in an approval, or if the provider elects not to request a consultation, the denial letter informs the provider and member of the right and procedure to initiate an appeal.

Aetna makes written and telephonic notification available to the provider, and we complete an NOA and send it to the member for any decision made to deny, reduce, suspend, or terminate a service authorization request. Our UM program description and policies and procedures describe the information contained in the NOA, which includes a description of members' rights and the process to file an appeal or request a State Fair Hearing. Our Member Services line assists members with questions about care determinations, NOAs, and appeal processes.

[BA039] Policies and Procedures for Medical Necessity with Prescription Limitations

Consistent with Aetna policy, we conduct medical necessity reviews for physician administered prescription medications as well as outpatient medications dispensed at the pharmacy when the pharmacy benefit is carved in. We provide medications sufficient in amount, duration, and scope to reasonably expect to achieve the purposes for which the prescription medications are furnished and are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan. Aetna uses formal protocols and processes to support the clinical review of physician administered drugs under the medical benefit that require PA and/or medical necessity review for prescription limits. Aetna may also refer to the BMS Preferred Drug List drug criteria when making determinations for physician-administered drugs as well as outpatient prescriptions drugs dispensed at the pharmacy when the pharmacy benefit is carved in. The Aetna Clinical Policy Review Unit develops and updates Aetna Clinical Practice Bulletins and guidelines to support the medical necessity review of prescription drugs in alignment with nationally recognized treatment standards (i.e., American Psychiatric Association, National Comprehensive Cancer Network, evidence in peer-reviewed published medical literature, expert opinions of health care providers, and information from public health agencies and the U.S. Food and Drug Administration.

During the medical necessity review, appropriate Aetna staff researches a member's authorization history before approving medications to avoid duplicating medications the member is already receiving, authorizing medications that are not in the member's benefit plan, and duplicating medication authorizations already documented in our system. Individuals who conduct the review are health professionals who possess an active professional relevant license

and are under the supervision of a medical director or designated licensed clinical professional qualified by training, experience, and certification/licensure to conduct case reviews. Determinations of medical necessity are made by qualified and trained practitioners in accordance with state and federal regulations. Only a medical director can reduce or deny a request for service based on a medical necessity review.

Authorization requests for medications that have no established medical necessity criteria, or for which application of medical necessity criteria are unclear, are sent to a medical director for review. The medical director conducting the review must have clinical expertise in treating the member's condition and be qualified by training, experience, and certification/licensure. The medical director reviews the request, the member's need, and the clinical information presented. Using the approved criteria and medical director's clinical judgment, a determination is made to approve, deny, or reduce the service. If the reviewing medical director determines that all applicable medical necessity criteria are not clear or application of criteria to this situation is in question, the medical director may do as follows:

- Submit a request for a position determination to the Aetna Clinical Policy Council, which will research literature applicable to the specific request and respond with a determination.
- Contact the requester to discuss the case or consult with a board-certified physician from an appropriate specialty area before determining medical necessity.

Throughout the process and after the determination, Aetna makes peer-to-peer consultation available to our treating practitioners with Aetna medical directors related to medical necessity requests and members' care needs. The Aetna CMO/medical director is responsible for directing and overseeing medical necessity review services and for ensuring the appropriateness of our clinical decision-making.

Members and prescribing practitioners are annually notified of medical pharmaceutical criteria and updates by mail, fax, email, or on our website. Additionally, medical necessity criteria and practice guidelines are distributed at no charge upon request to providers, members, and potential members.

To improve efficiency and ensure parity in coverage of outpatient prescription drugs which includes physician administered drugs, Aetna has implemented our Pharmacist Review of Medical Drug (PRMD) program for many of our state Medicaid plans with great success. We can implement the PRMD program in West Virginia consistent with West Virginia Department of Health and Human Resources, BMS, Chapter 518A Physician Administered Drugs.

Our team of clinical pharmacists comprise our highly effective PRMD program team. As depicted in **Figure 6.2.1-2,** they ensure that outpatient medical drugs are reviewed appropriately and meet medical necessity coverage requirements stated in BMS Chapter 518A and consistent with BMS Chapter 518, Pharmacy Services.

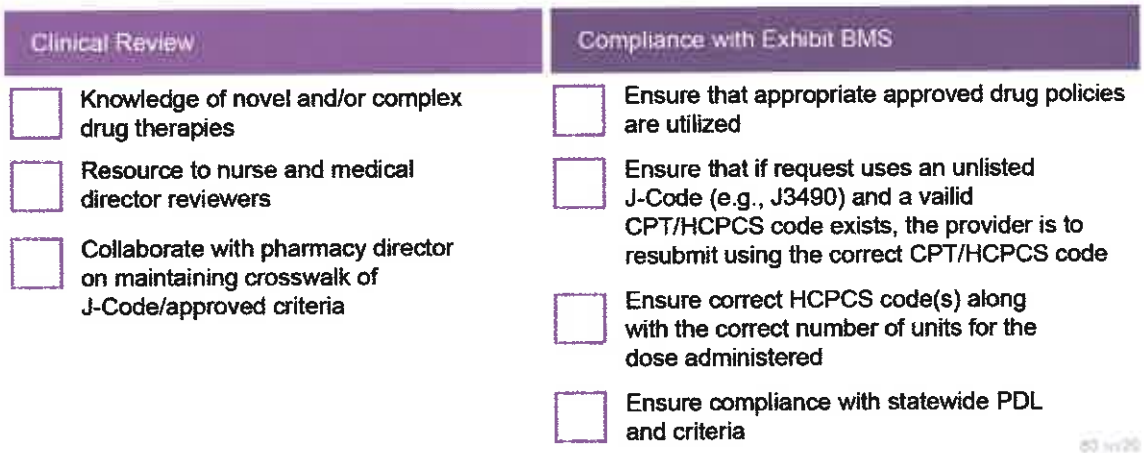


Figure 6.2.1-2: Pharmacist Review of Medical Drug Program Clinical Review and Compliance

Clinical pharmacist review of compliance with BMS requirements for outpatient medical drugs.

Since the PRMD program's inception in 2017 for one of Aetna's largest Medicaid plans, we have found that the clinical pharmacist's extensive knowledge of novel medications and injectable drug therapies assists our medical director and nurse reviewers. In the first half of 2019, PRMD clinical pharmacists reviewed 1,782 outpatient medical drug requests, approving 64 percent of cases based on medical necessity criteria and providing the nurse and Claims team with appropriate Healthcare Common Procedure Coding System (HCPCS) dosing for the authorizations. They consulted with the medical directors on the remaining cases recommending denial due to request not meeting medical necessity (17.1 percent) or needing additional clinical information (18.9 percent).

Access to Care

BA020	The Vendor should describe its process for authorizing out-of-network access including, but not limited to, the following:
BA021	Emergency Services, including transportation
BA022	Medically Necessary Travel, for the West Virginia Children's Health Insurance Program (WVCHIP)
BA023	Medical Necessity
BA024	Out-of-State Providers (for example, members who are students, live in proximity to State borders, etc.)
BA025	The Vendor should describe its process for circumstances under which a member might be granted a standing referral to a specialist provider
BA026	The Vendor should describe the extent to which a specialist provider may refer services
BA027	The Vendor should describe its process for out-of-network referrals, including, but not limited to:
BA028	Members and/or providers requesting out-of-network referrals
BA029	Processes in which a member may continue an existing relationship with an out-of-network providers, or a provider that leaves the Vendor's network, if considered to be in the best medical interest of the member
BA030	Durations permitted for members to see out-of-network providers that refuse to contract with the Vendor for ongoing courses of treatment past the first 90 days of enrollment

BA031	The Vendor should describe its procedures for ensuring that member information from non-network providers is shared with the member's Primary Care Provider (PCP).
BA032	The Vendor should describe its process to assist in enrolling and pairing the member with an appropriate in-network provider within 90 days of enrollment.
BA033	The Vendor should describe its process for transferring necessary clinical information to a member's new provider.

Currently, Aetna has contracts with approximately 11,000 providers, including primary care providers (PCPs), medical specialists, BH specialists, and all federally qualified health centers (FQHCs) and rural health clinics across West Virginia. In cases where a member's current provider is not contracted or when a provider type does not exist in the area, we will authorize services to provide continuity of care for our members. Aetna is already contracted with the majority of WVCHIP providers and is performing outreach to contract with others.

To ensure continuity and coordination of care, especially during times of transition, Aetna will work with providers and members to provide access to out-of-network providers and services and transition members to in-network providers when appropriate, in compliance with all relevant requirements presented in the Model Purchase of Service Provider Agreement for Fiscal Year 2020, Section 5.2, Out-of-Network Services. Within our role as a managed care organization, Aetna's provider contract language covers the appropriate and confidential exchange of information among providers and requires that all providers request information from other treating providers as necessary to provide care. When a member chooses a new provider within Aetna's network, we assist them with requesting the transfer of their records to the new provider.

[BA020] Authorizing Out-of-Network Access to Providers and Services

When necessary to meet a member's unique, whole-person needs, Aetna allows out-of-network services for both non-emergency and emergency situations. Prior authorization is never

required for in- or out-of-network emergency services. Out-of-network providers are invited to join the network, and single-case agreements are initiated when necessary.

We will follow WVCHIP referral and PA regulations and policies for our WVCHIP members, recognizing those guidelines and benefits differ from Medicaid. We will modify our tracking systems to accommodate these differences to ensure our WVCHIP members do not experience gaps in continuity of care.

[BA021] Emergency Services

Aetna permits the delivery of medical and BH services for the treatment of emergency conditions in-network or out-of-network without PA in the following situations:

- To screen and stabilize the member when a medical practitioner deems emergency services are required
- When an attending physician determines the member's life will be endangered or other serious injury could occur if the member is discharged and/or treatment is delayed
- When a delay or lack of treatment would subject the member to severe pain that cannot be adequately managed without the health care service or treatment being requested
- For service or treatment of an SUD or co-occurring mental health disorder within a partial hospitalization program or crisis stabilization unit needed to keep a member from requiring inpatient services

If a member requires medically necessary acute care after an out-of-network emergency room visit, Aetna covers the out-of-network hospital fees until care can be transferred to a network hospital or through discharge. **Aetna informs our members that emergency care is available 24/7/365, at the nearest facility available, regardless of the emergency room's provider participation status**. Aetna covers services for emergency transportation by ambulance for emergency medical conditions.

[BA022] Medically Necessary Travel for WVCHIP Enrollees

Aetna will adhere to WVCHIP benefits for emergency ground or air ambulance transport to the nearest facility able to provide needed treatment when medically necessary. Hospital-to-hospital

and all air ambulances, except emergencies (which are subject to retroactive review), require prior authorization. WVCHIP members participating in the hemophilia program will be reimbursed for travel and lodging expenses in accordance with program guidelines: lodging expenses for a child and one or two adults/guardians incurred to enable the member to receive services; and travel expenses incurred between the member's home and the medical facility to receive services in connection with program, including gas reimbursement for one vehicle and meal expenses up to $30 per day per person.

Members in the organ transplant program will be eligible for travel allowance up to $5,000 per transplant. Because transplant facilities may be located some distance from the member's home, benefits include up to $5,000 per transplant for member travel, lodging, and meals related to visits to the transplant facility or physician. A portion of this benefit is available to cover the travel, lodging, and meals for a family member or a friend providing support. Receipts are required for payment of this benefit. No alcoholic beverages will be reimbursed. Mileage will be reimbursed at the federal mileage rate for medical expenses. The travel allowance benefit applies only to services pertaining to the transplant.

[BA023] Medical Necessity for Out-of-Network Access

In non-emergency situations, PA for out-of-network providers is a two-part process: 1) review of medical necessity for the requested service, and 2) verification the services cannot be performed by in-network providers. In our review, consideration is made to assure our member's smooth transition of care. The initial step in reviewing a service request is the same for both in-network and out-of-network providers. When a request is received, the clinician applies medical necessity criteria per the clinical guideline hierarchy. If the service is determined to not meet

medical necessity criteria, the request goes to a medical director for further review. The UM clinician reviews network adequacy to provide the requested service to determine whether it can be provided in-network. The clinician may approve the request when medical necessity and network deficiency are determined. The request is forwarded to the medical director for a determination when the clinician cannot determine medical necessity or network deficiency, since only physicians can authorize denials. If there is an adverse determination based on network adequacy for a service that is considered medically necessary after review by the medical director, our CM staff works with the provider and member to access an in-network provider for delivery of care.

[BA024] Out-of-State Providers

Prior authorization processes for out-of-state providers are the same as for out-of-network providers, excluding for those out-of-state providers who are in our network. Except for emergency and family planning services, PA is required for all out-of-state, out-of-network providers to service our membership. To serve our members who live near state borders or who are attending school in other states, we have approximately 4,000 out-of-state in-network providers, many of whom are located in communities near state boundaries.

[BA027] Out-of-Network Referrals

Aetna covers out-of-network services for emergency services, family planning services, and those services we have prior authorized. If Aetna is unable to provide necessary medical services covered under the contract within our network of contracted providers, we will coordinate these services adequately and in a timely manner with out-of-network providers, for as long as we are unable to provide the services in-network. All out-of-network services are

covered as adequately and timely as in-network services, and member costs for covered benefits are the same whether the provider is in-network or out-of-network.

Aetna works with out-of-network providers to bring them into the network when possible and uses single-case agreements requiring the provider to treat our members with the same degree of care and skill they provide to patients who are not Medicaid members. If the provider declines to contract with Aetna, the Provider Relations team will identify opportunities to fill the possible service gap via recruitment, telemedicine options, or identifying a vendor. Aetna assists members with accessing State-funded transportation and room and board for out-of-network services that are out-of-state or that a member cannot access without additional support.

For medically necessary admissions resulting from out-of-network emergency services, Aetna covers a member's out-of-network hospital fees until the member's records, clinical information, and care can be transferred to a network hospital, no longer meets medical necessity for continued hospitalization, or until such time as the member is discharged, whichever is shorter.

Aetna's written policies, procedures, and workflows outline the criteria and methods we use to review and process medical referrals. The average duration of medical referrals varies, based on the type of service requested and our UM guidelines. For example, the average referral for home health is approved within five to seven days, while the average referral for therapeutic services (e.g., physical therapy) is approved within two weeks.

Aetna follows National Committee for Quality Assurance or West Virginia-required timelines (based on which is most stringent) for our decision and notification processes. Our written UM policies and procedures are in accordance with 42 CFR § 438 Subpart F, 1915(c) Waivers or

State policy. Aetna consistently exceeds the required decision and notification timeframes outlined in **Table 6.2.1-4**.

Table 6.2.1-4: Authorization Request Types and Decision/Notification Timeframes

Request Type	Decision/Notification Timeframe	Timeframe Met (2019)
Drugs/medications urgent concurrent request	24 hours from receipt of request	98.44%
Urgent pre-service request (including drugs/medications)	2 calendar days from the receipt of the request	97.39%
Non-urgent pre-service request (including drugs/medications)	7 calendar days from the receipt of the request	99.71%
Post-service request	30 calendar days from the receipt of request	99.97%

[BA028] Members and Providers Requesting Referrals

We educate members to contact Aetna's Member Services or their PCP to discuss referrals to out-of-network providers. The ordering provider must submit a service authorization request to Aetna for approval of out-of-network services. We inform members and providers they can appeal if we do not approve a service authorization request, and we describe the process to request out-of-network services in our provider manual and member handbook.

If Aetna is unable to provide necessary medical services covered under the contract within our network of contracted practitioners and providers, we will coordinate these services adequately and in a timely manner with out-of-network providers, for as long as we are unable to provide the services in-network. We will provide information for the member to arrange the service. The member does not incur additional cost for seeking these services out of network.

[BA029] Continuing Existing Relationships with Out-of-Network Providers

Although PA is required for out-of-network providers, we grant accommodations during transitions of care to allow new members to maintain established relationships with out-of-network providers for 90 days, or longer in special circumstances, as we work to establish in-network options to meet the member's ongoing needs. For example, if a member is in the course of cancer treatment or has an established relationship with an important provider, when requested by a member or provider, Aetna may grant an extension to complete the course of therapy to avoid a disruption in care, depending on the type of service and the member's place in the timeline of treatments. Concurrently, we work with members and providers to find providers within our network to provide the service, facilitating a smooth transition of care for our members if we are unable to contract with the provider to join our network. Aetna establishes single-case agreements with out-of-network specialists in West Virginia or outside the state when medically necessary and the specialty care is not available within our network.

[BA030] Durations Beyond the First 90 Days of Enrollment

Requests for continuation of out-of-network services beyond the first 90 days of enrollment are reviewed individually. Approval or denial of these requests are dependent on the availability of services in-network, within reasonable travel distances, and the condition that resulted in the request. As outlined above, Aetna may extend extensions in special circumstances.

[BA031] Sharing Information from Out-of-Network Providers with PCPs

Sharing information across multiple in-network and out-of-network providers is of prime importance to ensure the highest quality of care for our members. Aetna requires out-of-network providers to share information with other providers as appropriate contractually through single-case agreements. Aetna actively reviews claims data to identify when members see out-of-

network providers, and we send letters to our PCPs notifying them and reminding them of their contractual obligation to request the member's records from the out-of-network provider. Our staff follow up with PCPs to ensure they request member records when needed.

As an enhancement to our current processes, we encourage all providers, in-network and out-of-network, to use the West Virginia Health Information Network (WVHIN) to access and share information using continuity of care documents, as well as admission, discharge, and transfer (ADT) information, which contains the minimum necessary information to coordinate care. Leveraging technology developed for the recently awarded Mountain Health Promise contract, **Aetna is building an integrated care platform using WVHIN and continuity of care information.** The system will significantly enhance information-sharing capabilities and options between the health plan and out-of-network providers and PCPs.

For our members who are enrolled in care management, Aetna's regionalized local Care Connection teams foster information sharing through the strong relationships they have developed with providers of all types across West Virginia. We assist our members in requesting and acquiring their service authorizations, care plans, and claims history through Aetna's member portal, which they can share with their new provider. Care coordinators share information regarding non-network provider claims and services with the member's PCP. Aetna network PCPs are also invited to use our electronic population health management platform, which collects and displays data on their utilization, including non-network providers. Our new enhanced care planning processes feature a single document, the **enhanced care plan output letter**, containing easy-to-read information from the member's care plan, including diagnoses,

treatment, medications, and other community-based services, that is shared with the member's PCP. Behavioral health information is shared with appropriate member consent.

Aetna's single-case agreements require the provider to cooperate promptly with requests for information and records necessary for Aetna to properly administer claims, resolve member grievances, comply with reporting requirements related to the Affordable Care Act, perform quality management activities, and fulfill data collection and reporting requirements (e.g., HEDIS). When requested, medical records must be provided within 14 days.

[BA032] Pairing Members with In-Network Providers

Aetna works with members to ensure their transition to a provider within our network is as seamless as possible. In line with our member-centric focus, Aetna's methodology for connecting members to an in-network provider within 10 days of enrollment takes into consideration member preference, claims history, proximity, and existing relationships with PCPs or specialists. In cases where the assignment is to a PCP, we inform members that they have the right to select their PCP at any time by calling Member Services. We are continuously building our network, and if a member requests a PCP who is not currently a participating provider, we will contact the provider to discuss the provider's interesting in becoming a par provider within the Aetna network. If a new member does not select a PCP with the Department during initial enrollment, Aetna assigns a PCP. If a member was previously enrolled with Aetna, we auto-assign them to their previous PCP.

All WVCHIP members will be assigned to a PCP or medical home. If they do not have a medical home, or if their current PCP is not in our network, Aetna's Member Services staff will assist WVCHIP members in finding an in-network medical home PCP. We understand WVCHIP

members have been encouraged to participate in medical homes and certain co-pays are waived for office visits to their medical home provider. We will work to credential all enrolled PCP medical homes to add them to our network and will assign WVCHIP members with these providers when possible.

[BA033] Transferring Clinical Information to Member's New Provider

Aetna facilitates the transfer of pertinent medical records, recognizing that providers are responsible for making member records available to health plans to which members are transferring and/or to other providers upon request, in compliance with confidentiality requirements of Health Insurance Portability and Accountability Act of 1996, CFR42, part 2, and all state and federal regulations. Our network provider contracts require providers to obtain consents or authorizations to release information and records from the members they serve. All in-network provider contracts and single-case agreements with out-of-network providers require providers to share medical records with other providers. At a minimum, providers should transmit medical records related to diagnostic tests and determinations in the past 60 days, current treatment services, all immunization and EPSDT records, hospital discharge summaries within the past year, current medications, specialist referrals within the past 60 days, BH quarterly summaries, and emergency care summaries.

For over 23 years, Aetna has successfully integrated care for new West Virginia populations and services. For example, in July 2019 we successfully transitioned over 20,000 new members in West Virginia. We understand the challenges related to accessing comprehensive and historical data for some new Medicaid and WVCHIP members may require us to seek information from multiple sources, such as claims data from the State and health risk questionnaires.

We assist our members in requesting and acquiring their service authorizations, care plans, and claims history through Aetna's member portal, which they can then share with their new providers. For our most vulnerable members, those receiving intensive or supportive care management, care coordinators share information regarding provider claims and services with the member's PCP. Our new enhanced care plan output letter contains easy-to-read information from the member's care plan, including diagnoses, treatment, medications, and other community-based services. The enhanced care plan output letter is shared through Aetna's provider portal. BH information is shared with appropriate member consent.

We notify providers when their patients see other providers and remind them of their responsibility in requesting member records from these providers. Our electronic population health management platform houses ADT data from WVHIN and other health information exchanges and Aetna member gaps in care data. In addition, we encourage all providers, in- and out-of-network, to use the WVHIN to access and share information using the available data and continuity of care documents, which contain information necessary to coordinate care in near real-time. Aetna is actively collaborating with WVHIN to increase the amount of data available by increasing provider participation throughout the State.

Accessing Specialty Care

Aetna has an open-access network where members may self-refer or directly access in-network specialty providers without notice from their PCP or prior authorization. This means all Aetna members have access to any in-network specialist, regardless of specialty or subspecialty, without service limits to the duration or number of visits. We encourage all members to discuss specialty care with their PCPs, who can coordinate specialty services, which must be obtained

from an in-network Aetna practitioner or provider (when available). Emergency, family planning, FQHC, and rural health center services do not require PA for in- or out-of-network practitioners or providers. Members may access these services from any qualified practitioner or provider enrolled with the State of West Virginia Medicaid program.

Aetna will adapt our current PA processes, if necessary, to accommodate WVCHIP-specific benefit requirements and service limits, such as requiring PA after 26 specialty visits, 26 primary care visits, or 26 behavioral health visits.

[BA025] Granting Standing Referrals to Specialist Providers

If the specialist is in-network, no PAs or referrals are required. Aetna members who require specialized care over a prolonged period for a life-threatening, degenerative, or disabling conditions may be allowed standing referrals to out-of-network specialists or specialty care treatment centers. Determinations and notifications are made within the timeframes appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed seven calendar days from the receipt of the request. If clinical information is not sufficient to determine medical necessity, UM staff will make multiple attempts to obtain the needed information to ensure the appropriate decision is made as to not delay care. The process includes authorizing requests for standing referrals for members requiring more than one visit to a specialist or specialty care center for treatment of a condition.

[BA026] Allowing Specialists to Refer Members to Other Providers

When members have health conditions and needs that cannot be managed adequately by the specialist, Aetna allows direct referrals to other providers by the member's specialist or PCP. If the other provider is in-network, no PA is required, and our network providers are listed in the provider directory and via a searchable link on the Aetna website to facilitate these referrals. When access to

other providers is limited due to geographical and demographic barriers, Aetna's Care Management team facilitates identification of an out-of-network provider who can meet the member's needs. If the other provider is not in our network, PA is required for the service. We make every effort to bring these providers into our network to build capacity and enhance our ability to provide high-quality, accessible care for members.

Coordination of Care

BA040	The Vendor should describe its process for informing Primary Care Providers (PCPs) regarding changes in a member's behavioral health status including, but not limited, to:
BA041	What constitutes a change in behavioral health status
BA042	How the member will be assisted to access additional services as a result of a change in behavioral health status
BA043	The Vendor should describe its coordination of care activities between Primary Care Providers (PCPs) and children's dental providers, especially for children with special health care needs
BA044	The Vendor should describe its mechanisms to remind members of upcoming appointments, including, but not limited, to:
BA045	Medical Appointments and Screenings
BA046	Dental Appointments, and Screenings, including monitoring utilization and interventions if a member has not had a screening in over one year
BA047	Adherence to the periodicity schedule as dictated by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, as indicated by the Centers for Medicare & Medicaid Services (CMS) at https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

Aetna's Care Connection Team and System of Care models support and complement each other to provide a comprehensive approach to achieve optimal health outcomes and reduce costs and barriers to accessing care. While Aetna's regionalized Care Connection teams focus on the direct needs of our West Virginia members, our System of Care (SOC) model provides an overarching philosophy of care coordination based on addressing external factors that negatively impact health at the population level. For example, if the root

cause to a barrier to access for dental care is provider availability, our SOC would address the provider gap. If the barrier is transportation, our Care Connection team would assist the member in meeting that need. Our Care Connection teams are local regional teams that are from the communities in which they work and understand local concerns and complexities.

> *"Aetna currently collaborates with us to establish a payment model that support innovative programs in which community health workers become a recognized member of the health care workforce. I stress the word 'innovative,' because their leadership has always responded with an open mind whenever we present a new idea. Their attitude has always been to figure out how to make new ideas work, rather than to present obstacles. They do not stand on the sidelines; they truly are partners, in that they roll up their sleeves and participate in planning and problem-solving. Their work with us on the community health worker projects is a model that is transforming health care for high-risk populations. It is refreshing to work with people who genuinely care about the well-being of people in need."*
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> **— Richard Crespo, PhD**
> **Professor, Department of Family and Community Health**
> **Joan C. Edwards School of Medicine at Marshall University**

Aetna has embedded UM and CM staff with providers to ensure direct, face-to-face interactions with our members and foster seamless access to services. **Our staff are co-located in more than 20 physical and behavioral health provider locations throughout West Virginia,** working with providers in real-time to ensure our members are receiving the highest quality of care. In recognition of the importance of additional support for our members with BH needs, Aetna employs a statewide peer support specialist and a recovery and resilience administrator.

Our goal is to expand our members' care team and integrate Aetna teams with local providers and resources. Aetna collaborates with community programs to provide community health worker (CHW) resources to the Care Connection teams. CHWs meet with Aetna's onsite care management staff weekly to discuss member care plans, gaps in care, social needs, and care coordination. Recognizing the importance and value of the vital services CHWs provide in care

coordination, Aetna has led efforts to support CHWs in FQHCs by paying for CHW services and integrating these services into our member's care teams.

[BA044] Reminding Members of Appointments and Screenings

Aetna reminds and encourages our members to use benefits to prevent illness in compliance with requirements set forth in the Model Purchase of Services Agreement for Fiscal Year 2020, Section 3.5.2, Health Education and Preventive Care. Aetna has well-developed mechanisms to remind members who are enrolled in care management of medical, dental, and EPSDT appointments and screenings. Recognizing many new Medicaid and WVCHIP members will not require care management services, we will hire two additional care management associates who will be dedicated to providing reminders to members not enrolled in care management to provide follow ups and outreach to all EPSDT service members, in compliance with requirements outlined in Model Purchase of Services Agreement for Fiscal Year 2020, Section 1.2.1.1, Provide Information on EPSDT and Notification of Screening Due Dates.

In collaboration with our CVS retail pharmacies, Aetna can add member messages on prescription bags, called HealthTag™, reminding members identified as not having completed routine screenings to schedule an appointment to get the screen. Examples include reminding members with diabetes to get their A1c screening or for adolescents to schedule well-child appointments.

[BA045] Reminding Members of Medical Appointments and Screenings

Aetna reminds our members of screenings annually through multiple modes of communication, including the following:

- Mailings
- Text campaigns
- Live telephone calls
- Aetna staff embedded at provider offices and hospitals
- Care management staff (if applicable)

For Aetna members enrolled in intensive or supportive care management (adults and children), each member's primary care coordinator reminds members, parents, or guardians of appointments and assists with scheduling and rescheduling appointments with support from the local Care Connection team. Aetna care managers encourage members to keep scheduled appointments by sending an email or text message prior to scheduled appointments, which includes the date and time of the appointment and the phone number to notify when the member may arrive late or miss the appointment. Aetna care managers embedded in provider locations provide reminders related to follow-up appointments for members. The care coordinator reminds members of needed medical appointments and screenings.

Aetna Member Services representatives have access to gaps in care information in the electronic care management system and provide reminders to members and their families to schedule needed appointments when a gap in care is identified in their record. Care coordinators make calls to members to improve attendance at scheduled appointments and reduce missed appointments. The care coordinator also works with the member's providers to identify immediate gaps in care and unaddressed needs. If the member cannot continue with an established care provider, the care coordinator will assist the member in requesting the transfer of records and make sure the new provider addresses member needs.

Aetna's **texting campaigns** provide all members who accept the option to receive texts with notifications for physical, dental, and routine screenings (including family planning) based on member age, gender, and eligibility. We send these messages to members or their parents for whom the date of their last physical examination has either not been received or is more than

one year in the past. Aetna uses text messaging to provide periodic reminders to encourage members and their families to attend preventive care appointments. We assist members in acquiring Lifeline mobile phones if they do not have a phone to receive texts. Messages are delivered in either English or Spanish, depending on member preference, and members can choose not to receive text messages at any time.

Aetna uses text messaging, which we will extend to WVCHIP members who accept the option of receiving texts, to encourage families of children receiving EPSDT services to access dental care, well-child visits, and to complete lead screenings. Our educational text messaging program provides the Lifeline smartphone and sends targeted messages to remind income-level qualified members to get tests and screenings. Campaigns send routine reminders to support health goals related to weight management, diabetes, substance use, prenatal and postpartum care, well-child visits, and flu shots. Many campaigns function as virtual health coaches allowing members to interact and learn more about their specific conditions. Some of the unique monthly broadcast messages include reminders on keeping contact information current with the local Bureau for Children and Families office, emergency room diversion, and the importance of seeing their PCP first.

[BA046] Reminding Members of Dental Appointments and Screenings

Aetna reminds pregnant members to get bi-annual dental cleanings covered by Aetna during pregnancy. We send mailings to our qualifying diabetic members letting them know Aetna will cover quarterly periodontal scaling and root planing as a value-added service. Aetna's HEDIS outreach coordinators and/or prevention and wellness coordinators call all members to advise of care gaps and provide education regarding the importance of dental care for

children beginning at an early age. We help members find a dental providers and invite members to dental wellness events typically held in targeted regions or offices with below average HEDIS dental rates in collaboration with PCPs.

Aetna and SKYGEN USA, our dental benefits administration subcontractor, and our Care Connection teams use written and verbal methods to inform members about upcoming initial and periodic dental screenings. Aetna's approach covers both medical and dental outreach services. SKYGEN USA has 25 years of experience working with Medicaid and CHIP populations and leverages multimodal communications strategies to notify members of upcoming and periodic dental screenings for applicable populations, including interactive voice response (IVR) outreach campaigns and education materials for members.

SKYGEN USA provides a call center to educate members and assist with making appointments. When members reach out to the call center, they are educated about the importance of keeping appointments and their responsibility for calling the dental provider to reschedule if they cannot keep an appointment. This messaging is also included in our member handbook, member portal, and member outreach materials. Aetna supports member needs for regular dental care and maintenance and helps providers understand the importance of oral health in every primary wellness examination and transition.

Dental services for members with special needs: When communicating with and making arrangements for members with special health care needs, Aetna's care coordinators encourage the identification and consideration of past trauma (including dental trauma), the member's cultural beliefs, and provider office environment. We emphasize the importance of choosing a dentist experienced in meeting the member's needs and an office that includes the

environmental setting most appropriate to meet the individual's specific needs. When appropriate, our care coordinators conduct warm handoffs to SKYGEN USA to obtain further support. These coordination efforts are vital to ensuring the member receives all necessary dental services and all services are provided in a trauma-informed and trauma-sensitive manner. With support from Aetna staff when necessary, SKYGEN USA's local provider representatives provide trauma-informed care training for participating dentists.

If the SKYGEN USA call center is contacted to arrange for the provision of dental services for a member with special needs at an inpatient or outpatient facility, the customer service representative can call the provider's office on behalf of the member to confirm the provider serves individuals with special needs and treats the member's specific needs. Additionally, the call center will confirm that the provider sees members in the appropriate inpatient or outpatient facility and that the facility can provide dental services under anesthesia or sedation for children who are unable to be served in a general dental office.

Monitoring dental screening utilization: Dental gaps in care are monitored on an ongoing basis by Aetna's QM Outreach team through our electronic care management system. Members enrolled in care management are monitored for gaps in care, including the need for dental examinations. When we identify individuals who need dental examinations, a QM outreach coordinator reaches out to provide education and assist in scheduling appointments. For members who are not in care management, designated care management associates will monitor and screen for EPSDT standards of dental services, then provide outreach to members as appropriate to ensure compliance.

SKYGEN USA develops specific reports to monitor and analyze dental screening utilization and periodic (monthly/quarterly/annual) analysis of demographics, claims, and encounter data to identify high-risk populations within the membership. Aetna will work closely with SKYGEN USA to define the required data and data integration strategies needed to appropriately monitor dental screening utilization on an ongoing basis.

Intervening with members not having annual dental screenings: Aetna collects information about members' dental screenings and access to dental care during the initial health risk questionnaire as well as EPSDT screenings and during member transitions of care. Aetna's local Care Connection team identifies dental gaps in care and collaborates with the ICT to address them as part of the care planning process, particularly for new members. We regularly evaluate access data, emergency room data, and claims to better understand the gaps in some of our most remote areas. Our QM Outreach team conducts data analysis on claims and encounters to determine service areas with the highest volume of care gaps. The QM Outreach team collaborates with dental wellness providers in these geographic areas to increase access and health literacy for members needing services. Aetna quality management outreach coordinators conduct outreach to members and their families with gaps in care residing in these areas to provide education on the need of dental exams.

To incentivize dental care, we currently offer a $25 Walmart gift card to the parents of two- to three-year-old members who complete an annual dental visit and to members 0 to 20 years old who attend one of our dental wellness events by invitation. In 2019, Aetna members earned 349 gift cards by participating in these programs. Aetna's evidence-based **Diabetes Oral Health program** for adult members with diabetes increases member engagement with PCPs and

dental providers to improve HbA1c levels and medication adherence and reduce emergency room visits and hospital admissions.

[BA047] Reminding Members about Early and Periodic Screening, Diagnosis, and Treatment Services Guidelines

Aetna maximizes the opportunity to enhance member and parent education about the HealthCheck program and EPSDT services and requirements with every interaction. Aetna's National Quality Team sends telephonic reminders and periodic EPSDT mailings to all age-appropriate members based on age and the periodicity schedule. We routinely work with our members and parents to arrange for an EPSDT screening within 30 days of enrollment. Care coordinators also educate members on the periodicity schedule. We explain the EPSDT guidelines to parents and caregivers in plain language, paying particular attention to the guidelines immediately applicable to their children, with actionable next steps. Aetna care coordinators are experts in EPSDT guidelines and closing gaps in care and are well-versed in the scope of services, products, and treatments available under the HealthCheck program. Aetna identifies gaps in care, missed appointments, and immunizations through our electronic care management system and assigns staff to monitor EPSDT compliance. **Aetna will hire two additional care management associates to ensure all eligible members receive reminders, follow ups, and outreach for EPSDT services.**

We promotes comprehensive awareness and education for parents and caregivers of children and youth. We provide all new members and families with welcome contacts, information on medical homes, and resources (e.g., Medicaid dental list, vision care provider list, and transportation assistance). Aetna will augment prevention efforts through preventive screening reminders and additional education and training throughout the year to help members, parents,

and caregivers understand the importance and potential health impacts of timely and complete screenings. These efforts include IVR (interactive voice response) calls, mailings, text messaging, member services, website information, and live events:

- **Print media and mailings:** All our print media is carefully created to be concise and easily understood. We mail postcard reminders and newsletters with age-appropriate recommendations as well as growth charts printed with the well-child visit schedule.
- **Electronic text reminders:** We use text messaging to remind parents, caregivers, and members with phones that support text messaging about the importance of well visits, and send reminders about upcoming appointments, lead screening, and more.

SKYGEN USA supports increased utilization of EPSDT screening services and necessary diagnostic and treatment services for members under the age of 21 through the following:

- Assisting members with finding appropriate in-network dental providers and scheduling appointments
- Assisting members with arranging or scheduling transportation to appointments
- Arranging interpreter services for members with limited English proficiency or members who are hearing impaired, deaf, and/or blind
- Sending out communications to heads of households and PCPs for members who are due or overdue for their EPSDT appointments based upon their birthdates and utilization data
- Collaborating with the dental director and the local Care Connection team if any medical or other complex needs are identified for our members
- Provide data to enhance our informatics system platform for a single care plan for our members

[BA040] Communicating Changes in Behavioral Health Status

As a National Committee for Quality Assurance-accredited managed care organization, Aetna analyzes collaboration between our PCPs and BH providers annually. When we have the required consent of members, strong communication links between PCPs and BH providers facilitate two-way exchange of relevant information, such as medical history, current medications, diagnosis, treatment, and changes in BH status. Our Provider Services team provides education about the importance of coordination of care and encourages sharing of information across the plan to improve care for our members. Medicaid and WVCHIP members

can give permission to their BH providers to communicate with their PCP, including treatment and changes in their BH status. Information is only shared with the consent of the member or their parent or guardian.

Aetna annually assesses all members for new PH and BH needs and conducts reassessment more often as indicated by a change in condition. We review the member's care plan and develop a specific follow up schedule based on risk level. All initial and subsequent care planning activities are tracked in the written care plan and in Aetna's care management business application system. Aetna has designed an information management system for the purpose of integrating all components of the delivery of care to our members. The system has the capability to securely store and transmit information and interfaces with subcontractors and other relevant systems, including the West Virginia Health Information Network, the Department's Medicaid Management Information System, and report data in a format specified by the Department. The Aetna Medicaid organization has years of experience with HL7 transaction format and will be Fast Healthcare Interoperability Resources-compliant as directed by the Centers for Medicare & Medicaid Services. The data systems are integrated so that the member's data can be compiled in one central source. The information is housed within our integrated informatics system.

[BA041] Defining a Change in Behavioral Health Status

Aetna understands challenges West Virginians face with mental health issues, addiction, and trauma, and we are committed to helping our members access the care they need in the least restrictive treatment setting possible to maintain safety and facilitate recovery. A change in BH status is identified when a member's BH needs can no longer be safely met in an outpatient setting and a higher level of care is indicated. This includes admissions to inpatient BH, crisis

stabilization units, psychiatric residential treatment facilities, and any of the ASAM residential levels of care. A change in BH status would also include subsequent discharge back to outpatient services.

[BA042] Assisting Members in Accessing Additional Services

Following notification of admission, our UM staff refer members for CM services if the member is not already assigned. In multiple settings, our onsite CM staff meet with members during their stays to begin planning post-discharge services, or CM staff reach out to members following discharge for assessment and continued coordination of care. In instances where we are given consent by the member, we can reach out to the member's PCP and other providers for further coordination of care.

To serve our members who qualify for our CM program as a result of their BH needs best, we conduct initial and annual comprehensive assessments to identify new or emerging needs. On an individualized basis, Aetna or the member's provider may determine the need for additional services, and we assist the member in accessing these services. For example, a member being discharged from an inpatient setting for substance use disorder may benefit from participation in an intensive outpatient program, or a young person being discharged from a psychiatric residential facility may require intensive services within their home or therapy services while attending school.

Regularly scheduled contact and use of assessments following events which may have altered a member's health status provides valuable feedback to evaluate a member's progress toward their person-centered goals and to determine if the current care plan is meeting the member's current needs. Working closely with the member, we identify providers for services identified in

the care plan, and the member selects a provider based on their preferences and cultural considerations. We assist with scheduling appointments and addressing any barriers to accessing services as needed.

[BA043] Coordinating Care between Dentists and Primary Care Providers Especially for Children with Special Health Care Needs

Aetna care coordinators facilitate coordination of care between dental providers and PCPs, especially for children with special health care needs. These efforts are vital to ensuring the member receives all necessary dental services and that all services are provided in a trauma-informed and trauma-sensitive manner. Our model of care coordination provides a seamless, cohesive experience for members and their parents or guardians. We review gaps in care for all members in CM, and we help find dental providers and schedule appointments, documenting all activity in the member's enhanced care plan. The enhanced care plan output letter (a summary of the member's care plan) is sent to the member's PCP when formulated upon enrollment and with updates as the member's condition or situation changes. The care plan is shared with specialty providers, including dentists, upon request with the appropriate signed release of information. Our Care Connection teams and SKYGEN work with members and their families to ensure care is coordinated between dentists and PCPs and assist members with any issues they may experience in accessing dental care.

Family Planning

BA034	The Vendor should describe its process for member access and coverage of Family Planning

Aetna provides access to and coverage of family planning services for our Medicaid and WVCHIP members of childbearing age in compliance with the Model Purchase of Service

Provider Agreement for Fiscal Year 2020, Section 1.2.4, Family Planning and Section 5.3.3.1, Family Planning.

Ensuring Access to and Coverage of Family Planning Services

We provide members with direct access to women's health/family planning specialists and PCPs for routine and preventive health care services within our network. Our members also have the opportunity to choose qualified family planning providers outside our expansive network of providers if desired. We make every reasonable effort to contract with all local family planning clinics and providers throughout the state, such as local health departments, health system-affiliated family planning clinics, and FQHCs. We are currently contracted with 45 of the 49 West Virginia public health departments to ensure our members have access to family planning services statewide. Of those public health departments not contracted with Aetna, one has decided to not contract with plans, and the remaining three are in the process of becoming Aetna network providers.

Perinatal Partnership

Aetna's senior director of medical management and our obstetrics/gynecology (OB/GYN) medical director are working with the Perinatal Partnership in quarterly meetings to provide education to providers on LARCs and other family planning options.

We work to assure timely payment for family planning services, and our claims system processes family planning-related services with limited edits. In accordance with OBRA 1987 Section 4113(c)(1)(B), Aetna does not require co-pays, PA, or referrals for family planning services accessed through any in- or out-of-network Medicaid provider. Aetna tracks and monitors family planning services utilized by our members to identify gaps in services and to improve our education efforts. Family planning services are included in encounter data reported to the Department.

Our System of Care team also tracks the data reported and identifies opportunities to improve access to services for our members and reduce administrative burden for our providers. When the CM team identified an issue with providers not routinely providing long-acting reversible contraception (LARC) because reimbursement of the medication was bundled into delivery, Aetna unbundled the LARC payment from the delivery payment.

Informing Members about Family Planning Services

Aetna provides members with information about the types of family planning services available, their right to access these services in a timely and confidential manner, and their freedom to select their provider of choice. We are committed to providing health education and counseling services to our members so they can make informed choices concerning contraceptive methods and are knowledgeable about the diagnosis and treatment of sexually transmitted diseases. Our care coordinators provide education in a culturally sensitive manner, including information on the LARC program and other forms of birth control. Our Care Connection teams provide local resources for our providers and members. Each of our regional Care Connection teams has a specialized OB care manager to assist our high-risk members with access, care coordination, family planning education, and resources on all benefits, including LARC.

In 2019 we expanded our local resources and now co-locate care management staff at high-risk OB/GYN offices and tertiary care facilities, including the Charleston Area Medical Center Women and Children's Clinic and Marshall high risk OB/GYN clinic, to provide education on LARCs and other forms of birth control face-to-face. Additionally, CM staff reach out to all our new mothers to encourage them to discuss family planning and birth control options with their providers during postpartum appointments. Our care managers

complete a postpartum assessment in our electronic care management system that reviews family planning and reach out to members with any gaps in care.

The Aetna website contains a women's health section describing well-woman checkups, as well as pregnancy and family planning information. All information related to members' access to family planning services is available in the member handbook. Every pregnant member receives *Aetna's Baby Book*, which focuses on the importance of postpartum care, and these members can access educational materials on a variety of family planning topics available in electronic and print formats, including the following:

- Birth control choices and types
- Understanding conception
- Tubal sterilization surgery
- Using a condom (for teens and adults)
- How birth control works
- Understanding vasectomy

Crisis Stabilization

BA035 The Vendor should describe its process for accessing crisis stabilization services

Aetna recognizes and applauds the Department's efforts to expand access to BH services for residents of West Virginia in crisis. This includes the addition of services through the Substance Use Disorder (SUD) waiver, including improved access to Institution of Mental Disease facilities and the expansion of

Crisis Intervention

Mary[3] called Aetna's Member Services line looking for immediate help to keep her from using drugs. Our member services representative contacted a care manager through instant messaging while the member was still on the line and completed a warm transfer.

Mary disclosed to the care manager how abusing substances was ruining her life and that she feared if she did not get into treatment today, she would use drugs this evening.

Our care manager was able to connect Mary with a drug treatment center of her choice, and together they spoke with a crisis counselor at the center. Once Mary was comfortable, our care manager dropped off the call so Mary could discuss options and make plans for treatment with the center.

[3] Not her real name

residential rehab facilities across the ASAM continuum, funding of Quick Response teams to help engage individuals with SUD, expansion of children's mobile crisis response and stabilization teams, and the development of additional services through the Children with Serious Emotional Disturbance waiver.

Aetna has over 23 years of experience working with all inpatient BH facilities, crisis stabilization units, and State-approved residential rehab facilities in West Virginia to coordinate crisis services for our members when care at a lower level would not provide adequate safety. Aetna is made aware of members in crisis in multiple ways: face-to-face visits, a member contacting his or her care manager directly, members presenting in crisis at a site in which an Aetna care manager is co-located, admission alerts to higher levels of care, and our internal 24/7/365 toll-free BH Crisis Services hotline.

Any time of day or night, every day of the year, we are available to assist members during vulnerable episodes. As shown in **Figure 6.2.1-3**, when members call our Member Services line in crisis, staff follow Aetna's crisis situations desktop protocols. We prepare our Member Services and Care Connections team

Peer Support Provides a Lifeline

David[4], a member with substance use disorder, suicidal ideations, hypertension, atrial fibrillation, and depression, suffers from post-traumatic stress syndrome from traumatic childhood events from foster care placement and serving in the Army in Iraq.

He had been admitted as an inpatient for substance abuse and suicidal ideation three times before engaging with Aetna's peer support specialist late in 2019. Within a month, David has secured a job, attends Narcotics Anonymous meetings, and has made all his PCP appointments.

Our peer support specialist provides coping techniques and strategies for combatting depression, providing positive reinforcement for David's simple goal - to stay clean and sober one day at a time.

[4] Not his real name

staff to effectively help members in crisis by providing extensive training, including trauma-informed and BH training. For members presenting with a life-threatening emergency or those who are deemed a threat to themselves or others, Member Services staff warm-transfer calls to Care Connection team care managers who help de-escalate the crisis while working with appropriate team members to engage emergency services. We stay on the line until emergency services arrive. The member's primary care manager is notified of the crisis call to engage in follow up after the event. If crisis situations arise when Care Connection team staff are onsite with the member, we remain with the member throughout the incident. They continue to check in with the member on a regular basis to make sure the crisis is adequately addressed.

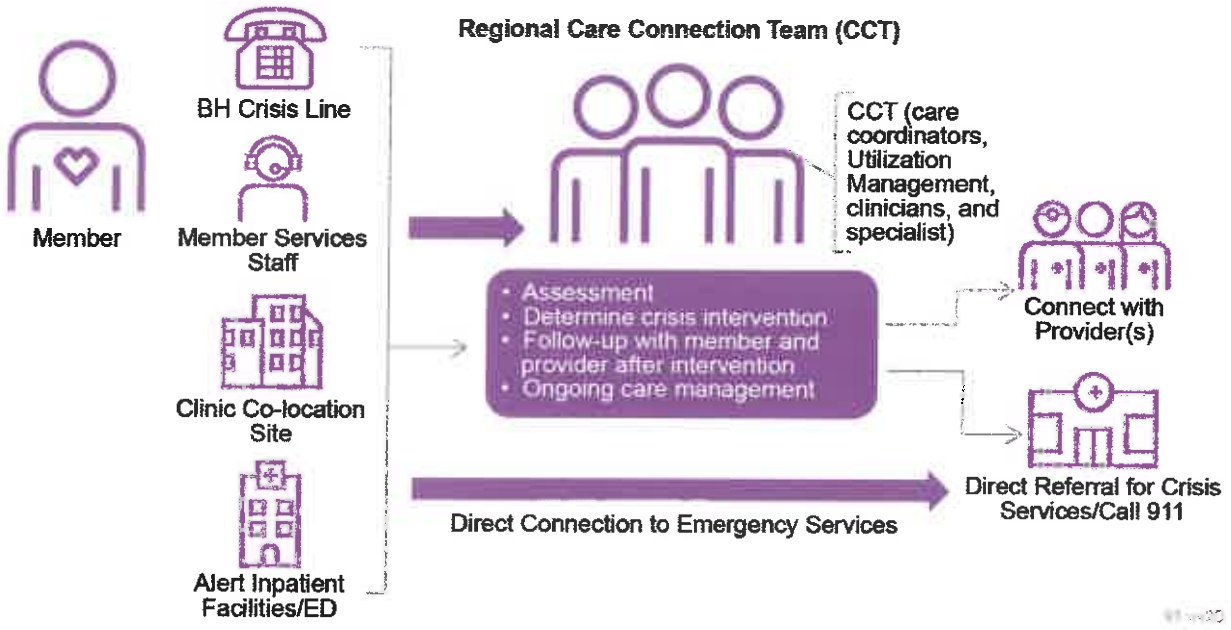


Figure 6.2.1-3: Pathways to Crisis Management

Aetna's goal is to ensure our members in crisis have immediate access to the appropriate level of services in the highest quality, least restrictive setting compatible with member safety and clinical efficacy.

In addition to direct contact initiated by the member, Aetna also identifies members in crisis through alerts to higher levels of care, including admission to inpatient BH crisis stabilizations

units and State-approved residential rehabilitation centers. Our Care Connection team care managers reach out to these members in-person through Aetna staff co-located within the facility, Care Connection team staff living in the community, or by telephone following discharge.

To ensure there are services for any member in crisis at all times in West Virginia, Aetna's internal, 24/7/365 toll-free BH Crisis Services hotline is fully and seamlessly integrated into our overall service array. Staffed with independently licensed BH professionals trained in supporting the needs of our members, the BH Crisis Services hotline connects members who may also call immediately to the crisis response system and can patch directly to 911 emergency services. Aetna's recruiting and hiring practices include strategies to hire personnel that represent similar cultural considerations to our members. We employ BH Crisis Services hotline staff who are certified bilingual in Spanish, and we use Language Line for 24/7/365 real-time interpretation of more than 200 languages.

Aetna will support West Virginia in becoming a national leader in disrupting the crisis cycle at all levels of the system by thinking creatively and exploring innovative ideas to solve intractable challenges, including building capacity around positive behavioral support, facilitating short-term respite, and taking a prevention-first approach.

Early and Periodic Screening, Diagnosis, and Treatment

BA036	The Vendor should describe how they will comply with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program requirements, as indicated by the Centers for Medicare & Medicaid Services (CMS) at https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

Aetna's network provides accessible comprehensive and preventive health care services to all eligible members. These services, which do not require PA, include EPSDT requirements of routine screenings, developmental screenings, and social/mental/physical health screenings as

listed in Section 1950(a) of the Social Security Act as mandated by the Omnibus Budget Reconciliation Act of 1989. Aetna provides notification of screening due dates, complies with the State-determined periodicity schedule, makes and tracks referrals and treatments, and reports results in our encounter reporting and as necessary to meet federal requirements.

Aetna has written policies and procedures for providing the full range of EPSDT services to all eligible Medicaid and WVCHIP enrollees up to age 21, in compliance to provisions in the Model Purchase of Service Provider Agreement for Fiscal Year 2020, Section 1.2.1 Early and Periodic Screening, Diagnosis and Treatment Services. We recognize members will go back and forth between Mountain Health Promise and Medicaid and WVCHIP, and we will leverage our years of successfully managing services for MHT's children and youth as well as the experience we will gain as the sole managed care organization for the West Virginia's new Mountain Health Promise program to ensure these transitions are smooth.

Aetna also works with providers through value-based purchasing to encourage compliance with EPSDT. For example, our value-based agreement with Marshall includes quality measures for well-child visits (three to six years), adolescent well care, and childhood immunizations; and our value-based agreement with Charleston Area Medical Center includes quality measures for annual dental visits (children two to three years) and childhood immunizations.

Table 6.2.1-5 provides key HEDIS® measures for child and adolescent wellness and preventive services for Aetna's current West Virginia Medicaid members.

Table 6.2.1-5: Selected EPSDT 2019 HEDIS Measures for Aetna West Virginia Medicaid Members

HEDIS Measure	HEDIS 2019	HEDIS 2018	HEDIS 2017	HEDIS 2016	Quality Compass 50th Pctl Met/Not Met
Adolescent Well Care	61.31%	58.39%	55.90%	39.86%	Met
Adolescent Immunization (Combo 1)	85.16%	86.62%	85.14%	83.90%	Met
Well Child Care 3-6 Years	76.40%	75.91%	71.93%	72.13%	Met
Well Child Care 0-15 Months (6 visits)	73.24%	72.99%	63.68%	66.59%	Met
Annual Dental Visit (Total)	64.18%	63.06%	61.04%	58.95%	Met

Informing Members about EPSDT

Aetna sends telephonic reminders and EPSDT mailings to all age-appropriate members based on age and the periodicity schedule. As detailed in our response to **[BA047]**, we routinely work with our members and parents to arrange for an EPSDT screening within 30 days of enrollment. Care managers explain the EPSDT guidelines and services available under the HealthCheck program to parents and caregivers in plain language, paying particular attention to the guidelines that are immediately applicable to their children.

Determining Medical Necessity for EPSDT Services

Aetna determines medical necessity for EPSDT services for our members on a case-by-case basis, taking into consideration the needs of each child. EPSDT services, offered via the HealthCheck program in West Virginia, are fully covered and are key to making sure children and adolescents receive appropriate preventive, dental, vision, BH, developmental, and specialty services. Members are entitled to as many doctor visits, hours, and amount of any services as medically necessary for their individual conditions if authorized under EPSDT. Some

EPSDT services may require PA, and the HealthCheck program consistently reviews evidence-based guidelines to determine medical necessity. Aetna's guidelines cover the entire continuum of care and include specific considerations for children and adolescents.

Aetna also maintains a process for review of program exception requests. For example, as a result of providing EPSDT services for a member, a PCP may request a service that is not an Aetna-covered benefit. The process for reviewing a PA request for a program exception (a requested service that is not a covered benefit) includes the following:

- The provider requests coverage for items or services noted to be for a program exception or the request outlines benefits not covered
- The nurse collects all necessary information and provides it to the medical director, who uses the EPSDT federal criteria in accordance with the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50- 62. These criteria are taken into consideration in the course of each service authorization. We use the following guidelines when reviewing the request:
  - Payment or the procedure is not allowable according to the fee schedule, is a type of service covered by the program, and is generally accepted by the medical community (e.g., enclosed safety beds, lead abatement, adaptive car seats, adaptive strollers, or an air conditioning unit for a child with significant asthma)
  - The procedure is not experimental
  - There is medical necessity for the item or service
- We fax or mail the determination to the requesting member and provider and document activity in our electronic claims management system

Processes Specific to EPSDT Services

Aetna is committed to working with providers to make sure all Medicaid-eligible and WVCHIP members under the age of 21 receive EPSDT services through the HealthCheck program and their parents, caregivers, and providers use resources effectively. Staff from our UM, CM, QM, Provider Relations, and Member Services departments are all instrumental in the implementation of our EPSDT policy to meet West Virginia's requirements for making EPSDT services available and accessible to our members. Aetna leverages our extensive experience

implementing and maintaining EPSDT programs in West Virginia and other states to ensure children and adolescents receive comprehensive preventive, dental, BH, and developmental and specialty services.

Early detection, screening, and interventions are fundamental to identifying developmental, physical, and behavioral issues. To make sure children receive all necessary EPSDT services through the HealthCheck program, both members and providers are made aware of how to access services to identify possible delays in growth and development, when steps to address issues can be most effective. Aetna provides EPSDT screenings according to West Virginia's periodicity schedule and include, but are not limited to, the following:

- A comprehensive health and developmental history (including assessment of both physical and mental health development)
- An unclothed physical exam
- Laboratory tests (including blood lead screening appropriate for age and risk factors)
- Vision testing
- Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
- Hearing testing
- Dental services (furnished by direct referral to a dentist for children beginning 6 months after the first tooth erupts or by 12 months of age)
- Health education (including anticipatory guidance)
- Inter-periodic screenings to determine the existence of a suspected illness or condition, or a change or complication to a pre-existing condition

Aetna follows the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care as the guide for EPSDT services. We understand the challenges in meeting all the health care needs of our members and have a specific strategy to assist members and families in completing EPSDT through covered benefits in local pharmacies including immunizations, urgent care visits, follow up urgent care visits, and assistance with transportation and scheduling.

Aetna has been training the entire Medicaid organization, both department and plan staff as well as providers, to understand and implement trauma-informed principles. Aetna is collaborating with the National Council for Behavioral Health, a nationally recognized leader on trauma-informed care organizations, and our West Virginia staff completed the trauma-informed training in January of 2019. We are bringing a provider collaborative to West Virginia to support local communities with trauma-informed training and resources early in 2020.

Through our collaborative efforts and education activities with PCPs, parents, caregivers, and others, we promote timely completion of EPSDT services. We offer families a choice of providers who conduct ongoing developmental surveillance in accordance with medical necessity criteria specific to EPSDT. Aetna also educates members and families on the availability of a comprehensive suite of benefits, stressing well-child and preventive health visits.

Working with providers: Aetna engages in a robust provider education process to inform them about the West Virginia EPSDT periodicity schedule and requirements that PCPs must perform oral health assessments, evaluations, prophylaxis, and oral hygiene counseling. We also educate providers on adopting a trauma-informed approach while performing all EPSDT services, including conducting routine physical examinations; screening for developmental delay through the fifth year; screening for autism spectrum disorder; conducting a comprehensive unclothed physical examination; and all appropriate immunizations, laboratory testing, and health education during each medical screening. Education activities emphasize the importance of the use of validated developmental screening tools, with the expectation that providers will assist families with scheduling appointments for timely early periodic screening visits, and any

additional assessments, referrals, and follow up, as well as following up with families whose children miss their screening visits.

Reports Monitoring EPSDT Compliance

Aetna has implemented various strategies to monitor compliance in West Virginia and in 12 other states in which we serve children and youth that have proven highly effective in improving engagement in screenings and preventive services. We analyze our EPSDT screening and well-visit rates monthly and quarterly. Regular monitoring helps us to identify strategies that are working well and provides insights into areas where we may be able to overcome our members' barriers to care. Aetna will submit a report to the Department within 45 calendar days after the end of each quarter regarding EPSDT outreach services, and rates of screening and referrals, well-care child visit, dental visits, and immunization.

Aetna's regionalized local Care Connection teams review gaps in care and set task reminders for follow up visits for children age 5 and under with no screening, targeting children and youth with special health care needs who are behind on their screenings, and conducting outreach to parents/caregivers of members ages 0-20 who are behind in their in well-visit screenings. We track EPSDT requirements and related HEDIS measures, and the data is utilized to generate reports identifying early deficiencies. We use care alerts (which identify high- and medium-risk members who are behind in their care), priority lists, quarterly measures, provider profiles, tracking phone calls (automated and direct), and face-to-face contacts. Pediatric measures are shared with the network and practices quarterly for quality improvement purposes. We will generate an EPSDT profile for each provider or practice, which will include scorecards on items such as well-visit rates.

Aetna utilizes data and reporting to identify areas for continuous quality improvement. We examine the data collected to look for gaps in performance as well as measures with positive outcomes. We look for member, provider, and geographic differences, and search for any data issues that may be affecting performance. EPSDT oversight and compliance reviews include the following:

- Timely EPSDT screenings completed
- Timely completion of services members are referred to as part of EPSDT
- Authorizations for EPSDT services in utilization management
- Turnaround time reporting for key services related to EPSDT exams
- Claims audits to test claim edits and rules
- Identification of members who may need EPSDT screening or who have no record of completed services

In the event a member elects to have a specialist serve as his or her PCP, Aetna care managers reach out to the specialist to participate in care planning. If the specialist is new to performing the functions of a PCP, we educate them on the requirements of being a PCP and monitor them through gaps in care reports for relevant HEDIS measures and member feedback on appointment access or practitioner behavior. We provide ongoing support and use the same interventions as we would use for non-specialist PCPs.

For providers (both PCPs and specialists who function as PCPs) who show low compliance rates, the QM team reviews a sample of records for additional investigation. This assessment of outcomes becomes a part of the quality plan, and both the UM and QM teams review outcomes with the providers and CM team. We also encourage providers to perform well visits in tandem with acute visits to record preventive services through coding and emphasize that providers can either address EPSDT requirements while the member is in the office or schedule additional follow up for an EPSDT visit.

Member Co-Pays

BA001	The Vendor should provide its plan to impose, monitor, and track member co-pays and quarterly household maximums for including, but not limited to, the following:
BA002	Medical Services (includes Physical, Behavioral Health, Dental, and Vision)
BA003	Pharmacy Services

Aetna's plan to impose, monitor, and track member co-pays and quarterly household maximums for medical (physical, behavioral, dental, and vision) services is based on the member's income tier and is in compliance with requirements specified in the State Plan and the requirements set forth in 42 CFR §§447.50 - 447.82, as outlined in the Model Purchase of Service Provider Agreement Section 3.9, Cost-Sharing Obligations. **Aetna has never been sanctioned by the State for incorrect co-pay assessments.** We recognize the benefit and co-pay differences between MHT/ WVHB Medicaid and WVCHIP members and will adapt our processes to comply with all requirements. **[BA001]**

[BA002] Member Co-Pays and Quarterly Household Maximums for Medical Services

For Medicaid members: Medicaid members are assessed co-pays for non-emergency use of the ER, acute care inpatient stays, office visits, outpatient surgical services (except those provided in the ER), and pharmacy. With the exception of pharmacy, the amount of co-pay required is dependent upon the income tier level to which the member is assigned. Quarterly caps or maximum out-of-pocket payments are established based on family income. Pharmacy co-pays are the same for all Medicaid members regardless of income; however, out-of-pocket maximums do apply. Consistent with State Plan and contractual requirements, Medicaid exempts children under 21 years, pregnant women (including 60 days postpartum), foster children, members covered through the Breast and Cervical Cancer Treatment Program, individuals receiving hospice care, individuals whose medical assistance for services furnished

in an institution is reduced by amounts reflecting available income other than required for personal needs, and American Indians or Alaska Natives. Exempt services include BH services, emergency services, pregnancy-related services, family planning, preventive services provided to children under 18 years of age, and provider preventable services.

For WVCHIP members: WVCHIP members participate in cost-sharing (co-pays and premiums) based on enrollment group, except for children registered under the federal exception for Native Americans or Alaska Natives, and for those enrolled in WVCHIP Pregnant Women's coverage. Co-pays are waived for all office visits to a member's medical home. Aetna's system processes at the individual and family member levels by using the member's enrollment group benefit level. WVCHIP has three enrollment groups, each having a different cost share (Gold, Blue, Premium). Out-of-pocket maximums are applied during a benefit year and differ based on enrollment group, number of children, and amount is associated with medical or prescription services. Dental out-of-pocket maximums apply only to the WVCHIP Premium group. We will apply the value of premiums to the household maximum. The benefit set-up in the system ensures the correct co-pay amount is applied to claims. The system also tracks yearly member out-of-pocket based on the head of household indicted on the state enrollment file.

Processes for Medicaid and WVCHIP: Aetna will calculate the difference between the paid amount and the Medicaid-allowed amount compared to the sum of the co-insurance, co-payment, and deductible amounts, and will pay the lesser of either the difference amount or the summed amount. For FQHCs, the payment is defined as the encounter rate less the primary paid amount without consideration of cost-sharing. Aetna has a close relationship with SKYGEN USA and will be able to integrate dental co-pay accumulators with no issues.

Aetna educates contracted providers on the policies and procedures to collect co-payments from MHT/WVHB Medicaid and WVCHIP members. We reduce payments to network providers by the amount of the member's co-pay, regardless of whether the provider collects the co-pay.

Aetna has a process to track and monitor co-pays at the member and household levels for both the Medicaid and WVCHIP populations. Co-pays are established at the member level and household level in our system in the benefit administration module for medical claims. Yearly and quarterly maximums are also tracked at a household level for medical claims off-system. To incorporate pharmacy and dental co-pays (for WVCHIP), two-way data sharing is utilized. Internally, our analysts are able to incorporate medical, pharmacy, and dental data weekly to determine if the household maximum has been reached. This data is sent to SKYGEN USA, the PBM, and our internal claims system to place a hold on co-pays being charged to the member's household until the end of the quarter for Medicaid members and the end of the year for WVCHIP members. Additionally, we perform a quarterly reconciliation process using accumulative data shares to verify if households have exceeded co-pay limits, and if limits have been exceeded, claims are adjudicated to reimburse the provider, who will in turn reimburse the member.

[BA003] Member Co-Pays and Quarterly Household Maximums for Pharmacy

Aetna will leverage our experience from when pharmacy benefits were carved into the MCO responsibilities to impose, monitor, and track member co-pays and quarterly household maximums for Medicaid and yearly household maximums for WVCHIP members. We will work with the Department to implement systems to impose, monitor, and track member cost-sharing obligations that meet the State's expectations. If the pharmacy benefit is carved in to services

provided by Aetna, our PBM, CaremarkPCS Health, is able to perform out-of-pocket tiering based on member benefit level for pharmacy claims. Additionally, CaremarkPCS Health and Aetna have performed daily file shares to continually monitor and communicate household out-of-pocket limits in the past and have the capabilities to perform this in the future if needed.

Fraud and Abuse

BA010 The Vendor should describe its process for preventing and detecting fraud and abuse related to all administered services including Pharmacy, if applicable

Aetna takes our role as a steward of MHT taxpayer-funded appropriations very seriously. We are a member of the National Association of Medicaid Program Integrity, the Centers for Medicare & Medicaid Services (CMS) Health Care Fraud Prevention Partnership, and multiple health care anti-fraud task forces at the state and federal levels As a NCQA-accredited health plan with a 'Commendable' rating, we continually monitor our policies and procedures for fraud and abuse related to all administered services, including pharmacy, through audits. We conduct an annual review of policies and procedures, which our Policy and Procedure Committee reviews and approves.

Located in Charleston, Alva "Fuzzy" Page III, Esq., is the point of contact for the Department as well as internal Aetna staff regarding compliance and program integrity. Shannon White-Metz serves as program integrity lead and is the primary contact for all Department program integrity inquiries and issues, as well as conducting all program integrity efforts for the health plan. Aetna currently has three full-time Special Investigations Unit (SIU) staff dedicated to West Virginia. The West Virginia-based Program Integrity staff work

Aetna is a founding member of the National Health Care Anti-Fraud Association and the Medical Identity Fraud Alliance.

directly with our SIU and Compliance teams regarding FWA activities and Aetna's local prevention and detection efforts.

Aetna's West Virginia Program Integrity plan establishes internal goals identifying controls, policies, and procedures to ensure the prevention, detection, and deterrence of FWA in accordance with state and federal requirements. **Aetna enforces a zero-tolerance policy toward any form of FWA by staff, subcontractors, providers, members, or others.** The plan includes detection and prevention program activities for staff, members, caregivers, and providers, including reporting and follow up, continuous monitoring of compliance, identification and reporting of issues, and ongoing training and education.

Fraud, waste, and abuse training: All Aetna staff receive initial and annual training on our FWA and program integrity policies, Code of Conduct, and ethics. Initial provider training in FWA takes place during orientation, with ongoing supplemental training (such as self-auditing), conducted through provider forums, our secure online provider portal, the provider handbook, and individual communication with Provider Services staff. Provider training includes definitions of FWA, provider program integrity and compliance responsibilities, methods for preventing FWA, responsibility for reporting overpayments, and ways to report FWA to Aetna, BMS, West Virginia Medicaid Fraud Control Unit, and/or CMS.

We require all subcontractors to follow strict hiring and training processes to fulfill West Virginia Medicaid obligations, and we provide oversight and monitor their performance and compliance with our contractual requirements, which includes training their employees in FWA. We require our subcontractors provide documentation that verifies and certifies that their employees have received annual FWA training that is consistent with Aetna Medicaid and BMS regulatory

requirements. We hold quarterly joint operating meetings with our subcontractors to discuss goals and objectives, performance, and FWA.

Suspension of payments: Aetna complies with 42 CFR 455.23, which requires the state Medicaid agency to suspend all Medicaid payments to a provider after determination of a credible allegation of fraud for which an investigation is pending. We ensure all participating providers are enrolled with BMS as Medicaid providers prior to executing a provider agreement, and we cooperate with BMS when payment suspensions are imposed. **Aetna's program integrity savings for 2019 were more than $27 million, including overpayment and retractions.**

Preventing and Detecting Fraud and Abuse

Aetna uses a variety of techniques, analyses, and technologies to detect questionable billing practices and avoid fraudulent claims payments, including business intelligence software to identify providers whose billing, treatment, or member demographic profiles differ significantly from those of their peers. The Medical Management department may review claims to determine if the provided documentation supports the billing, if billed charges are necessary and reasonable, and to identify non-covered supplies and services,

Developing Policies to Combat Fraud and Abuse

As part of our ongoing, cross-departmental program integrity evaluation of substance use disorder treatment, urine drug screens (UDS), and related testing over treatment national FWA schemes within medication assisted treatment (MAT) programs, an analysis of claims data showed a significant increase in breath alcohol tests (BAT).

Claims review showed BAT being performed on the same day as UDS in a majority of MAT. Our medical directors consistently found there was no documentation of intoxication in the office or suspected alcohol use at the time of the visit that impacted treatment plans.

After discussion in the monthly FWA meetings and interdepartmentally with Provider Relations and Prior Authorization, a policy change was instituted in January 2019 requiring that all BAT claims require medical records for review of medical necessity.

in addition to inappropriate and undocumented charges. Cases of potential FWA are referred to the SIU department for review and disposition. Details on how UM guidelines support the detection and prevention of fraud and abuse are outlined earlier in this response in **[BA006-BA009].**

Member service verification process: Aetna sends letters to a random sampling of members each month containing billed claim information specific to that member. The notice asks the member to contact a telephone hotline manned by our Member Services staff if the services identified were not actually received. To generate the random sampling, we use a stratified sampling methodology with a segregation of professional and institutional claim type, each with three categories. Notices are generated within 45 days of payment of claims via United States Postal Service first class mail. All responses to the verification of services letters are tracked, and the SIU alerts the Department should a credible allegation of fraud be detected.

Fraud and abuse reports: Aetna's SIU analytics group 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. The SIU performs on going reviews of the plan to identify high-dollar specialties, high-utilization providers, and procedures codes. These reviews suggest to the SIU investigators which specialties/providers/codes to review for outlier behavior indicative of FWA.

In addition, on a quarterly basis, the SIU analytics group runs a minimum of 25 outlier reports generated from Aetna medical claims and West Virginia State Medicaid pharmacy claims data of known categories of fraudulent schemes, such as up-coding and billing for services that were not provided, based on specialty and current procedural terminology codes to identify the top

providers of certain services. At data mining meetings, SIU staff, the SIU medical director, and certified procedural coders discuss and prioritize data mining studies to better analyze trends and schemes identified through various sources. SIU investigators review the data mining report and take appropriate action. These reports are frequently updated and refined to stay current with evolving trends.

Aetna's rules-based electronic claims management system maintains and processes health care administration data, providing increased efficiency. The provider module contains a unique provider identification number generated by the system, plus all provider billing and tax reporting information. The QNXT claims module shows the date of receipt, history of actions taken on the claim, and date of payment, including the remit number. The electronic claims management system stores claims by specific benefit limits/lifetime benefit rules. It edits data for accuracy during claims processing and payment. Aetna's Medicaid Claim Quality Control department independently assesses the effectiveness of the Medicaid claims system configuration and claim procedures against the resulting adjudication process.

The electronic claims management system data (and legacy claims payment data) is utilized by Aetna's SIU through the Universal Web Information Directory (UWID) system, a decision support and reporting system that authorized Aetna SIU staff can utilize to meet business information needs. There are 45 unique static reports across, member, provider, pharmacy, and dental data. In 2018, over 4500 reports were run in the UWID system.

Aetna's SIU data mining is enhanced by Healthcare Fraud Shield (HCFS), a platform that has approximately 600 health care business rules and algorithms maintained and updated quarterly. HCFS business rules and algorithms are customizable at the health plan level to account for

benefit variations and can be applied pre- and post-payment. This platform identifies providers with potential FWA behaviors, allows for plan and national peer group comparison, and assigns risk scores. Aetna's SIU uses HCFS application screens to visualize all FWA leads and provider billing activity as well as download the past 24 months' worth of claims for each lead. This helps Aetna's SIU further avoid inappropriate billing, identifies and mitigates provider abrasion, and deters criminal activities by utilizing key FWA concepts.

Our SIU fosters a comprehensive approach to addressing both member and provider fraud by leveraging all available data sources to detect emerging fraud patterns. Aetna's SIU also receives and uses leads provided by the Aetna Enterprise Analytics Fraud team. Our data analytics system provides efficient and proactive discovery of new fraud schemes, allowing for near real-time prepayment review capabilities to flag suspicious claims and/or providers prior to adjudication. The data analytics of all Aetna plans are shared between the plans (commercial, federal, Medicare, Medicaid, et al.) to leverage the information on common providers and provider types. This information sharing leads to cost reductions for analytics and in the process of 'pay-and-chase' methods of recoveries.

Aetna Dental Super-Prescriber Program

As part of our commitment to combatting the opioid epidemic in West Virginia, Aetna implemented a Dental Super-Prescriber program to reduce the average days' supply of opioids prescribed by dental providers. Aetna is implementing initiatives to encourage non-opioid alternatives for treatment of pain after dental surgery, and we send educational letters to dental providers and oral surgeons with pharmacy claims exceeding a three-day supply of an opioid within the preceding one-year period. During the period of January to June 2019, as compared to July 2017 to June 2018, there was an 82 percent reduction in dental providers giving prescriptions with four or more days' supply of opioids (from 34 to 6 providers).

Preventing and Detecting Fraud and Abuse in Pharmacy

Aetna's SIU project lead for pharmacy tracks and reports ongoing pharmacy cases and audits monthly and handles medical pharmacy cases, including preparing cases to respond to requests from the West Virginia Office of Program Integrity and West Virginia Fraud Control Unit. Aetna's SIU, Pharmacy, and Medical Services teams work collaboratively with our providers and utilize the West Virginia Board of Pharmacy Physician Drug Monitoring Program to identify members at risk for adverse medication events and inappropriate or fraudulent use of prescription medications.

Aetna's collaboration with the Department around preventing and detecting fraud and abuse in pharmacy has evolved since the pharmacy benefit was carved out in July 2017. The Aetna Pharmacy team conducts ongoing monitoring activities, including routine audits, to prevent and detect FWA through the review of pharmacy claims made available from the State. Even with the pharmacy benefit carved out, pharmacy claims provided by the state enable Aetna's Pharmacy team to run, analyze, and take action on monthly and quarterly reports to identify members, pharmacies, and prescribers of concern. These reports are shared with appropriate CM, UM, QM, and Compliance team members to take next steps.

Providers (prescribers and pharmacies) of concern are discussed by the Pharmacy team with the medical director and Medical Services teams. When the Pharmacy team reviews prescriber utilization reports, they pay special attention to prescribers and practice group trends around high-cost medications, high-cost drug therapy classes, high-cost drug national drugs codes, high-dosage controlled substances, and the use of specific pharmacies for these medications. After review of the concerns, the medical director or designee may reach out to prescribers to

gather information to help the Aetna team gain a better understanding of the provider's prescribing behaviors. Additionally, as instructed by the medical director, a pharmacist will contact the identified provider for a review of their prescribing patterns. Outreach to the identified provider focuses on review of the analysis and education on appropriate prescribing practices. Information gathered by the pharmacist is brought to the team. When appropriate, the Aetna team, under the direction of the medical director, will engage our QM/UM Committee and Provider Services team to act, which may include quality of care referrals and investigations for outlier prescribers. Investigations may result in QM/UM Committee action, including corrective action plans, claims denial, or termination from the network. Lastly, if provider prescribing behavior necessitates, Aetna's SIU will be called in to review cases of outlier prescribing to identify potential FWA. The SIU will refer cases of FWA to the West Virginia Health and Human Resources Office of Inspector General for further investigation and potential sanctions.

Aetna's Interdisciplinary Care team (ICT), including our CMO/medical director, pharmacy director, a clinical pharmacist, and CM staff, reviews members of concern during member care conferences, paying special attention to member medication use indicating duplicative prescribed medications from more than two prescribing providers as well as excessive use of drug targets recently involved with fraudulent schemes, such as gabapentin, diabetic tests strips, asthma medications, Suboxone® and buprenorphine with concomitant opioids, and controlled substance cocktails of drugs (benzodiazepine and opioid combinations). With the goal of member safety, members identified with medication use behaviors consistent with fraud or abuse are outreached to by care managers who assess the member's medical, prescription medication, and social needs with the goal of better understanding the member's medication

use. Additionally, our care managers, with the support of our pharmacy director, will consult with the member's prescribers to identify needs and develop a plan for care. Members identified and acted upon for medication use issues are reviewed at least semi-annually by the ICT, and when indicated, our care manager will refer the member to the Pharmacy Supportive Care Management program.

In the **Pharmacy Supportive Care Management program**, monthly reports are used to monitor pharmacy utilization data to identify potential fraud or abuse. Medication use reports identify members who fill opioid prescriptions from more than 10 prescribers in 90 days, as well as members with possible doctor shopping behavior demonstrated by filling controlled substances (e.g., opioids, stimulants, etc.) from more than three prescribers or more than three pharmacies in the past 90 days. These targeting edits are combined with other **Supportive Managed Care Program (SMPC)** (our member restriction program) edits, such as presence of opioid abuse disorder or MAT to create a member ranking report based on total number of edits triggered by a member. This ranking report is reviewed to determine next steps within the program. If restriction is recommended by committee, referral is made to the state in accordance with Aetna's Supportive Managed Care Program (SMPC) Member Restriction Policy 7500.03:

- The focus of the SMCP program is to support members and their families with whole person needs, assisting members to improve their pharmacy and benefit utilization as appropriate to their health care needs and coordinating care with the member's primary care provider and other practitioners/providers as needed.
- Referrals to the SMCP may come from Aetna staff, practitioners, providers, caregivers/family members, or any state entity. All members proposed for enrollment in the program must be approved by the medical director. The member can be restricted to a practitioner, provider, or pharmacy. The restriction will be in effect for a period of up to one year or longer, depending on the state-specific contract.

In the event the pharmacy benefit is carved into the services provided by Aetna, we will work with our PBM, CaremarkPCS Health, who will adjudicate prescription claims consistent with the State's prescription benefit requirements and conduct retrospective claims reviews, audits, and investigations to prevent, detect, and take action on fraud and abuse demonstrated by pharmacies, members, and prescribers. Our PBM performs paid and rejected claims reviews using targeting logic built to validate accurate claims adjudication based on the benefit structure coded and monitors each pharmacy on all claims submitted. The team monitors claims to ensure appropriate fees and payment are adjudicated per contract terms. If an issue is detected, the team escalates the issue for expedient remediation; and if payment recoveries occur, they are provided to Aetna. Desktop audits occur daily, and onsite audits occur as needed to detect FWA at the pharmacy level, with results reported to Aetna for action as needed.

All pharmacy claims submitted by pharmacies via our point-of-service claims processing system are subject to edits that confirm pharmacy compliance with program parameters even before prescriptions are dispensed. A report is produced daily to check claims for inconsistencies in quantity and days' supply. When errors are detected, outreach is completed to the submitting pharmacy for resolution. All pharmacies are subject to desk audits based on high-cost reports. An automated statistical review, the Pharmacy Exceptional Activity Report (PEAR), is employed to identify pharmacies with unusual or improper claim activities that might indicate noncompliance with plan guidelines and pharmacies for an onsite audit to review prescription documentation to verify the integrity of the claims submitted and processed for payment.

To prevent fraudulent use of medications by members and prescribers, Aetna's pharmacy claims system can be set up with edits to stop inappropriate prescriptions from payment.

Examples of edits to prevent potential fraud and abuse include refill too soon, quantity limits, duplicate prescriptions, expired prescriptions, and maximum quantities of targeted drugs or products (such as muscle relaxants, anabolic steroids, gabapentin products, diabetes test strips, and rescue inhalers).

Additionally, to identify potential cases of fraud by members, Aetna can use CaremarkPCS' Retrospective Safety and Monitoring program that uses staff pharmacists to review members' medication profiles with claims identified as potentially fraudulent by proprietary algorithms and software This program identifies, corrects, and/or deters potential cases of misuse and fraud. The Safety and Monitoring program targets high abuse drug classes such as opioids, muscle relaxants, and stimulants and misuse behaviors such as provider shopping and duplicate therapy. Interventions include a letter to the prescriber and/or pharmacy and continual follow up and monitoring until case resolution or plan referral. All pharmacist activities are reported to the Aetna Pharmacy team on a monthly and quarterly basis. Situations identified as being potentially fraudulent are referred to our pharmacy director, SMCP team, and/or the SIU team pharmacy lead.

Aetna's Pharmacy, Medical Services, QM, and UM teams have implemented strategies to prevent and detect fraud and abuse in pharmacy whether the pharmacy benefit is carved out or carved in. Currently, the Aetna Pharmacy team conducts ongoing monitoring activities, including routine audits, if needed, to detect FWA through the analysis of monthly and quarterly reports derived from pharmacy claims from the State and takes actions as described above. Added layers of fraud and abuse detection, prevention, and management can be provided through pharmacy point-of-service claims, processing edits, and analysis of the triggering of those edits.

Analysis of drug use and prescribing and filling patterns of members, prescribers, and pharmacies, when the pharmacy benefit is carved in.

Pharmacy Rebate Resolution

BA037	The Vendor should describe its policies and procedures for assisting the State or fiscal agent with the pharmacy rebate resolution process including rejected or disputed physician administered drug claims.

Aetna has an established relationship with the State to maximize the rebate process, and we are working together to improve our encounter reporting to optimize the data to provide accurate and timely information regarding rebates. This includes utilizing the State's HCPCS-to-National Drug Code (NDC) crosswalk to deny claim lines that do not meet the specifications on the crosswalk. We meet with the State monthly to receive and provide feedback on the process. These meetings have also included discussion on how Aetna can be used as a catalyst in resolving rebate disputes. Since the spring of 2019, our information technology (IT) director has been working closely with the State's Office of Program Integrity and DXC to improve the State's rebate process as it pertains to MCO encounter files. Recommendations to the State include utilizing the type of bill to determine outpatient claims so universal billing (UB) claims can be properly processed for rebate purposes and removal of certain HCPCSs from the crosswalk that are non-rebatable. In addition, Aetna has continued to improve our system's scrub in conjunction with the State-provided crosswalk so there are a minimal number of rebate errors in the encounters sent to the State. Aetna continues to educate providers about proper billing to maximize rebatable data, including the utilization of the 340B indicator. Through the State's feedback from our monthly meetings, we educate our providers on improved rebate data on claims. As requested by the State, our encounter data integrity manager serves as the appointed plan liaison on all items regarding rebates.

Aetna understands and complies with 42 U.S.C. § 1396r-8, as applied to Medicaid managed care in accordance with 42 C.F.R. § 438.3(s), and all requirements set forth by BMS Chapters 518, Pharmacy Services and 518A, Physician Administered Drugs. We cover all outpatient drugs listed on the BMS Drug Rebate Detail Report crosswalk, regardless of the setting in which the drug is dispensed or administered and regardless of the billing provider type. The State drug list ensures that for drug codes requiring an NDC, coverage depends on the drug NDC status (e.g., rebate eligible, non-Drug Efficacy Study Implementation, non-termed, etc.) on the date of service. Additionally, Aetna understands drugs dispensed to Medicaid beneficiaries purchased under the 340B Drug Pricing program do not qualify for Medicaid rebates.

The most recent 2019 Aetna medical claims file submission resulted in a 99.99% state acceptance rate for over 48,000 claims with drug NDCs.

Limiting payment to only rebate-eligible outpatient covered drugs: Aetna, under the direction of the Department, has established business rules and processes that use the State of West Virginia Bureau of Medical Services' monthly NDC crosswalk file titled 'WVREFR054_Drug Rebate Detail Report,' which is sent via email from DXC to guide the payment of CMS rebate-eligible outpatient prescription drugs. If pharmacy is carved in, Aetna can work collaboratively with the State and our designate PBM to utilize this file to guide outpatient prescription claims processed at our pharmacies.

Upon receipt of the monthly crosswalk, Aetna uploads the crosswalk into our system for the Aetna Claims department to process physician-administered drug (PAD) claims. Provider-submitted PAD claims are matched against the Drug Rebate Detail Report data weekly, and medical claim lines with HCPCS and NDCs that do not match the crosswalk are denied. We

send remittance advise documents with the denied line and information about the invalid NDC and HCPCS to providers. The remittance denial language is "Missing NDC; CPT/HCPCS requires NDC data but claim is missing NDC data CPT/HCPCS requires NDC data and submitted NDC data is not on State file or is not active on State file." Our robust NDC medical claims edits validate all NDCs on physician-administered or outpatient hospital drugs and ensure accurate claims and encounter submission as depicted in **Figure 6.2.1-4**.

By the 15th of every month, Aetna submits a file for medical claims (including PADs) paid in the prior month consistent with the claims submission file requirements. Aetna reports the necessary outpatient drug encounter data to assist the Department in invoicing drug manufacturers for rebates for medical outpatient drugs. This includes NDC level information on drugs, biologics, and other provider-administered products as directed by the Department, including, but not limited to, HCPCS codes (e.g., J-code, Q-code, A-code) and diagnosis codes, units, and conversions consistent with federal and Department requirements, administering prescriber information (e.g., National Provider Identifier [NPI], professional address, etc.), and required financial elements and dates of service and payment. In turn, the State/Molina sends a monthly NDC rejection report via email to Aetna. Consistent with State expectations, Aetna corrects and resubmits information within 30 days of notice. Common data elements reviewed for CMS rebate compliance include claim status, payment status (claim level



Figure 6.2.1-4: Overview of Medical Claim Edits
Medical claims edits validate all national drug codes for physician-administered or outpatient hospital drugs to ensure accurate claims and encounter data.

and line item), procedure code, units of service equals procedure units, NDC code, metric quantity of the injectable equals NDC units, prescriber NPI, and current procedural terminology (CPT)-4 modifier/modifier 2 (340B identification). Per State direction, any request for the correction of fields specific to collecting rebates does not supersede the requirements listed.

340B Drug Indicator on Outpatient Prescription Drugs Claims

Consistent with Aetna's contract with West Virginia, we ensure all outpatient prescription drugs purchased at the 340B price and provided to our members are submitted to the state via pharmacy and medical claims encounters and include at the time of billing a 340B indicator supplied by the provider that verifies whether or not a 340B drug was dispensed/administered to the member. The PAD 340 modifier 'UD' is reported using the standardized template supplied by the State (State Contract, Article III §§ 5.11.12). 340B pharmacy claims and encounters are submitted with National Council for Prescription Drug Programs (NCPDP) field Submission Clarification Code (SCC) = 20, and/ or Basis of Cost (BOC) = 10.

Aetna educates our 340B entity providers on appropriate flagging of 340B claims.

Outpatient Medical Drug Audit

Aetna collaborates with Cotiviti to identify duplicate payments made on both a member's medical benefit platform and pharmacy benefit platform (when carved in). Provider verification is often required to validate who supplied the medication and to where the medication was shipped (e.g., facility, office, patient). In addition to this cross-platform audit of pharmacy and medical claims found within their respective platforms, other aspects are described in **Table 6.2.1-6**.

Table 6.2.1-6: Auditing Medical Outpatient Drug Claims

Component	Description
Excessive Drug Units	Claims and/or claim lines billing erroneous unit quantities for drug service codes. These billing errors are typically the result of a simple data entry mistake or an incorrect conversion of the drug's administered dose to the corresponding code's defined billing unit (HCPCS) increment.
Duplicate Services	Claims and/or claim lines where services are billed and paid in duplicate. These billing errors are often the result of services being billed by both physicians or outpatient clinics as well as the hospital in which these physicians and clinics provide their services.
Services not Rendered	Claims and/or claim lines in which a service was billed but not provided. This overpayment occurs when the drug code is billed but the drug is not given (billing error). These billing errors are often caused by situations such as appointment rescheduling, patient illness, or the incorrect inclusion of the drug with complementary services that took place on other dates (administration of other drugs, office visits, laboratory testing, etc.).
Charges/ Contracts	Claims and/or claim lines billing/paying incorrectly for drug service codes. These payment errors are typically the result of a simple data entry mistake or the incorrect application of a provider's fee schedule and/or contract when adjudicating claims.
Policy	Claims and/or claim lines billing/paying inconsistent with Department or Aetna policy.

All validation failure responses are captured on an NDC pend report, which is reviewed by the claims team and the pharmacy director to resolve issues. This is done before the check run (provider payment) to ensure valid NDCs are present, units are appropriate, and claim provider and financial information are present as predicted.

Manufacturer Invoice Dispute Resolution:

A CMS-participating manufacturer may dispute claim utilization provided within their respective quarterly invoice. Currently in West Virginia, the Department handles this process; however, Aetna has engaged in preliminary discussions on how to make the process more efficient by partnering with the Department. The Aetna Medicaid organization nationally also has experience creating dispute resolution procedures to resolve manufacturer/labeler invoiced and disputed

claims with other state Medicaid agencies' rebate vendors. Aetna works with these designated vendors to resolve manufacturer disputes and communicates with the billing provider to verify the NDC utilized on the claim and confirm the billed units dispensed. This process includes the following steps:

- If any information is incorrect, the billing provider is advised to reverse/void the original encounter claim and resubmit the corrected encounter claim
- The resubmitted claim(s) will contain the following: the correct NDC dispensed and quantity dispensed, and will have correct provider payment, considering any third-party payer on the claim
- Aetna adds dispute resolution comments and uploads to State-designated vendors' portals consistent with timeliness requirements
- If a provider has not responded to Aetna inquiries, the vendor is informed of the next steps that will be taken by Aetna to correct/resolve the claims in question

Provider Education on Proper Outpatient Drug Billing

We value our providers and continuously monitor claims to identify provider medical and pharmacy (when carved in) education opportunities for incorrect NDC/HCPCS outpatient drug billing. The pharmacy director collaborates with our local Provider Experience staff to engage those providers. We provide an overview document on NDC/HCPCS billing, which is distributed during provider orientation and ongoing visits and included in provider resources (welcome packet, provider manual, quarterly newsletters, and provider notices). We also include reference documentation on the provider portal and website. In addition, Aetna has hired a Provider Relations representative (PRR) to bring local support and quality expertise to the providers. The PRR works in collaboration with Provider Experience staff to deliver face-to-face provider education, and Aetna will further leverage its office presence for education on proper NDC/HCPCS billing. If pharmacy is carved in for prescription claims processed at the pharmacy, Aetna's pharmacy director works collaboratively with our PBM to ensure our network pharmacies are billing prescriptions claims consistent with requirements.

3. Care Management

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Care Management (CM) as part of their bid. The Vendor's narrative response should not exceed 125 pages.

For more than 23 years, Aetna has been focused on and dedicated to addressing the whole person needs of the children and adults enrolled in the West Virginia Medicaid program, currently known as Mountain Health Trust (MHT) and West Virginia Health Bridge (WVHB). Through our deep connection with West Virginians as a trusted managed care organization (MCO), we have learned that our members possess the solutions and skills to reach their full potential, and our job is to offer effective coordination to support them in their journey to better health and overall quality of life. As we will describe throughout this section, we offer excellence in our infrastructure, through **care management (CM) delivered by West Virginians in our regional Care Connection teams (CCTs) established throughout the state.** We promote self-sufficiency, recovery, and resiliency using person-centered care management approaches that are delivered locally, in the communities in which our members live. We meet members where they are, often through **face-to-face interactions** at members' homes or in their doctor's offices. We utilize evidence-based practices in the delivery of care management including motivational interviewing and the Charting the LifeCourse™ framework. We employ a fully **integrated care management framework,** a model we developed here in West Virginia that other Aetna programs across the country (including our Pennsylvania and Kentucky Medicaid plans) are now adopting. We conduct evidence-based assessments and develop **individualized enhanced care plans** to meet the unique needs of members, based on their conditions, self-identified health goals, and cultural preferences. Our population health management (PHM)

approach and activities to address prescription drug abuse focus on prevention in addition to the delivery of the right care at the right time. We operate within a **System of Care (SOC) model** that is committed to reducing barriers, improving access to care, and identifying and solving for system process needs through multi-department and community collaboration.

Our local team tailors our care management approach based on outcomes, while incorporating lessons learned in the other Medicaid markets we serve and best practices we have implemented in other states. In addition to our extensive experience serving adults and children in the West Virginia MHT and WVHB, **the Aetna Medicaid organization presently has Children's Health Insurance Program (CHIP) experience in 12 states** including Arizona, California, Florida, Kansas, Kentucky, Louisiana, Maryland, Michigan, New Jersey, Pennsylvania, Texas, and Virginia. For over 30 years, Aetna's national Medicaid organization has provided comprehensive medical services and coverage to CHIP enrollees, delivering strong health care outcomes in a cost-efficient and prudent manner. This experience informs our approach and drives our dedication to meeting the needs of the CHIP population in West Virginia. Our integrated, member-centered, family-oriented, and holistic methods guide our decision-making, inform our policies and culture, and foster our ongoing efforts with State agencies and their partners, providers, hospitals, health networks, and community partners to align economic incentives with quality outcomes.

Florida Healthy Kids Outcomes

Aetna Better Health of Florida had 54,000 Florida Healthy Kids enrollees in nine regions and recently received a statewide award adding 40,000 additional enrollees for this CHIP plan for a total of 94,500. Additionally, we achieved an 18% reduction in readmissions from 2018 to 2019 and a 14% reduction in ER visits in our Florida Healthy Kids plan.

Aetna recognizes that the **holistic evaluation of a member's circumstances and identification of rising risk, accompanied by delivery of services customized to their needs, can change the trajectory of members' lives**. According to a publicly available study by Population Health Advisor, approximately 18 percent of members identified with rising risk will escalate to high-risk status, if we do not identify the risk and offer the appropriate care in a timely manner.[1] Aetna is committed to identification of rising risk and throughout our response we describe our processes programs to address it.

As an indicator of assessing rising risk for adults, our focus on pre-diabetic screening resulted in a 2019 Healthcare Effectiveness Data and Information Set (HEDIS®) rate for hemoglobin HbA1c testing of 87%.

Our regional care management model is also designed with an understanding of the specific health care challenges and disparities West Virginians face. Based on analysis of the 2017 West Virginia Health Disparity report[2] and the *State Rural Health Plan 2018 – 2022*[3], Aetna understands that West Virginians face high rates of infant mortality, low birthweight, teen births, substance use (including smoking), diabetes, and chronic obstructive pulmonary disorder (COPD). West Virginia has been an epicenter for the opioid epidemic as evidenced by a 50 percent increase in drug deaths in the past three years.[4] We understand that social determinants of health (SDOH) have unique regional impacts, and that **where a person lives**

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[1] Advisory Board, "Addressing the Needs of Your Rising Risk Patients," Population Health Advisor: accessed January 18, 2020; https://www.advisory.com/-/media/Advisory-com/Research/PHA/Research-Briefings/2018/Addressing-the-Needs-of-Your-Rising-Risk-Patients.pdf
[2] Health Disparities 2017: accessed January 23, 2020; https://www.arc.gov/images/appregion/fact_sheets/
[3] West Virginia Department of Health and Human Resources, "Creating a Culture of Health in Rural West Virginia: State Rural Health Plan 2018-2022" (2018): accessed January 18, 2020; http://wvrha.org/wp-content/uploads/2017/08/2018-State-Rural-Health-Plan-Final.pdf
[4] America's Health Rankings Annual Report 2019: accessed January 30, 2020; https://www.americashealthrankings.org/explore/annual/measure/Drugdeaths/state/WV,

can have a greater influence on health outcomes than family medical history. Our regional CCTs have deep understanding of the particular SDOH factors that most impact members in the cities and counties where they live and work. We know that members in Putnam county identified a need for more employment opportunities and summer/after school programs and that in Boone county, members said they need better transportation to services and help with access to nutritious food.[5]

Additionally, Aetna understands that the West Virginia population faces increased likelihood of having experienced adverse childhood experiences (ACEs), which can be a barrier to accessing health care, achieving optimal health outcomes, and meeting personal goals for health and wellness.[6] We know that children who have experienced ACEs and trauma often have special health care needs early in life and chronic health conditions later in life. They need the highest quality of care and seamless coordination of services offered through individualized treatment to achieve the best possible health outcomes. The impact of ACEs and trauma on children and families cannot be overstated.

To address the key health disparities and unique challenges West Virginians face including the high incidence of opioid use disorder (OUD) and its impact on pregnancy and infants, chronic conditions such as diabetes and coronary artery disease, the prevalence of ACEs, and SDOHs, we have developed comprehensive, regional, and statewide care management initiatives and programs. These include our Neonatal Abstinence (NAS) Care Management Program,

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[5] EnAct Community Action, Community Needs Assessment May 2018: accessed January 18, 2020. http://enactwv.org/wp-content/uploads/2018/05/EnAct-Community-Needs-Assessment-Report-Final-without-Appendix.pdf.
[6] Adverse Child Experiences Coalition of West Virginia, "Stumbling Blocks or Stepping Stones: Findings on Adverse Childhood Experiences (ACEs) in West Virginia," (2018): accessed January 23, 2020; https://docplayer.net/96887761-Stumbling-blocks-or-stepping-stones.html.

known as Moms and Babies, our Diabetes Collaborative program, and the implementation of Unite Us, a closed-loop social needs referral platform. CCTs use the Unite Us platform to facilitate referrals that reduce SDOH-related barriers in accessing care. We have provided mobile food pantries in Boone and Kanawha counties where we know food insecurity is prevalent. We understand the impact of trauma and toxic stress on our members and have established trauma-informed care (TIC) as a cornerstone. We have taken proactive measures to become a trauma-informed transformed organization both nationally and at the local level. In collaboration with the National Council for Behavioral Health, we have also completed an organizational self-assessment of TIC awareness and policy implementation to identify additional opportunities for training, practice, or communication improvements and have provided extensive training to our staff and providers. Additionally, we developed programmatic relationships with federally qualified health centers (FQHCs) such as Williamson Health and Wellness to offer co-located care management in collaboration with their community health workers (CHWs) to offer one-stop hubs of care management and health services. We are expanding this model with other FQHCs including Cabin Creek, Community Cares, and Family Care. These programs, in addition to others we will describe throughout this response, are customized to the needs of individual West Virginia enrollees, and are delivered in collaboration with members and their care teams in their communities, to address the State's goals of enhanced coordination of care and access to services, enhanced quality of care, and reduced fragmentation to offer seamless continuity of care, to name a few. We continually work in partnership with members, their circles of support, their providers, and care teams to build on the individual strengths of our members. Collectively, we will be steadfast in our mission to

support West Virginians enrolled in the MHT, WVHB, and CHIP programs achieve the highest level of physical and mental health possible.

Local Care Management Staff Infrastructure

CM023	The Vendor should describe its staff qualification and training requirements for individuals who will be involved in coordinating care, including, but not limited to, any specialized care managers utilized for certain conditions
CM024	The Vendor should describe its process for hiring care management staff including, but not limited to, the following:
CM025	Staff qualifications
CM026	Plan for hiring
CM027	Timeframe for hiring
CM028	Total number of care managers to be hired
CM029	Maximum caseloads and ratios per care manager for Vendor-defined risk tiers
CM030	The Vendor should describe its process for monitoring and evaluating care managers in regard to establishing relationships with members including, but not limited to, statistics collected and frequency of collection

At Aetna, we support our members' attainment of a meaningful quality of life, optimal health, and overall wellness. CCTs operate within the context of our SOC model, and work to reduce the inequities and barriers members often face. Care management activities are delivered by Care Management staff who understand the available resources and employ effective strategies that support stability, build on members' capabilities, and help members achieve their life goals, in collaboration with provider, stakeholder, and community partners.

Care Connection Teams

Our regional CCTs include care coordinators, utilization management (UM) representatives, concurrent review clinicians, obstetrical (OB) specialists, behavioral health (BH) specialists, Serious Emotional Disturbance (SED) specialists, and SUD specialists who live in the regions in which they work. CCT Care Management staff titles include care management associates (CMAs), care management coordinators (CMCs), and

clinical care managers (CM-nurse, and CM-licensed clinical social workers [LCSWs]) that have extensive experience and training in conducting assessments, facilitating integrated care planning, utilizing clinical models, navigating the Medicaid system, and conducting ongoing care coordination. The configuration of our CCTs is flexible and is designed to meet the specific needs of local communities. If needed, we adjust staffing to meet regional demands (e.g., we increase the number of care managers with specific BH background or increase UM team staffing for members with complex medical needs). A **statewide peer support specialist** also supports the CCT to offer members additional support. Roles and qualifications for CCT members will be described later in the response. **Figure 6.3.1-1** depicts our regional Care Coordination teams as they are currently configured in West Virginia.

Given our longstanding presence in health care delivery in West Virginia, our regional CCTs have nurtured relationships over many years with state stakeholders and other community resources. We have established productive working relationships with the Department of Health and Human Resources (the Department), Child Protective Services (CPS), the Division of Corrections, the Bureau for Medical Services (BMS), the Bureau of Behavioral Health (BBH), Right from the Start (RFTS), Birth to Three, and Perinatal Partnership. CCTs have also built relationships with the local providers and community-based organizations to support smooth coordination of care with regard to care planning and securing services for members. We coordinate with multiple community agencies and have invited many to speak to our Care Management and UM staff during staff meetings. Some examples include guest speakers from the Children with Special Health Care Needs (CSHCN) program, the Ryan White Foundation, Resolve Family Abuse/YWCA, Women, Infants, and Children (WIC), and LogistiCare. Additionally, **we embed Care Coordination staff in many community locations** as described

in **Table 6.3.1-1.** These co-located relationships foster seamless access to service, increased communication, and improved coordination of care due to the proximity of CCT members to the direct service providers.

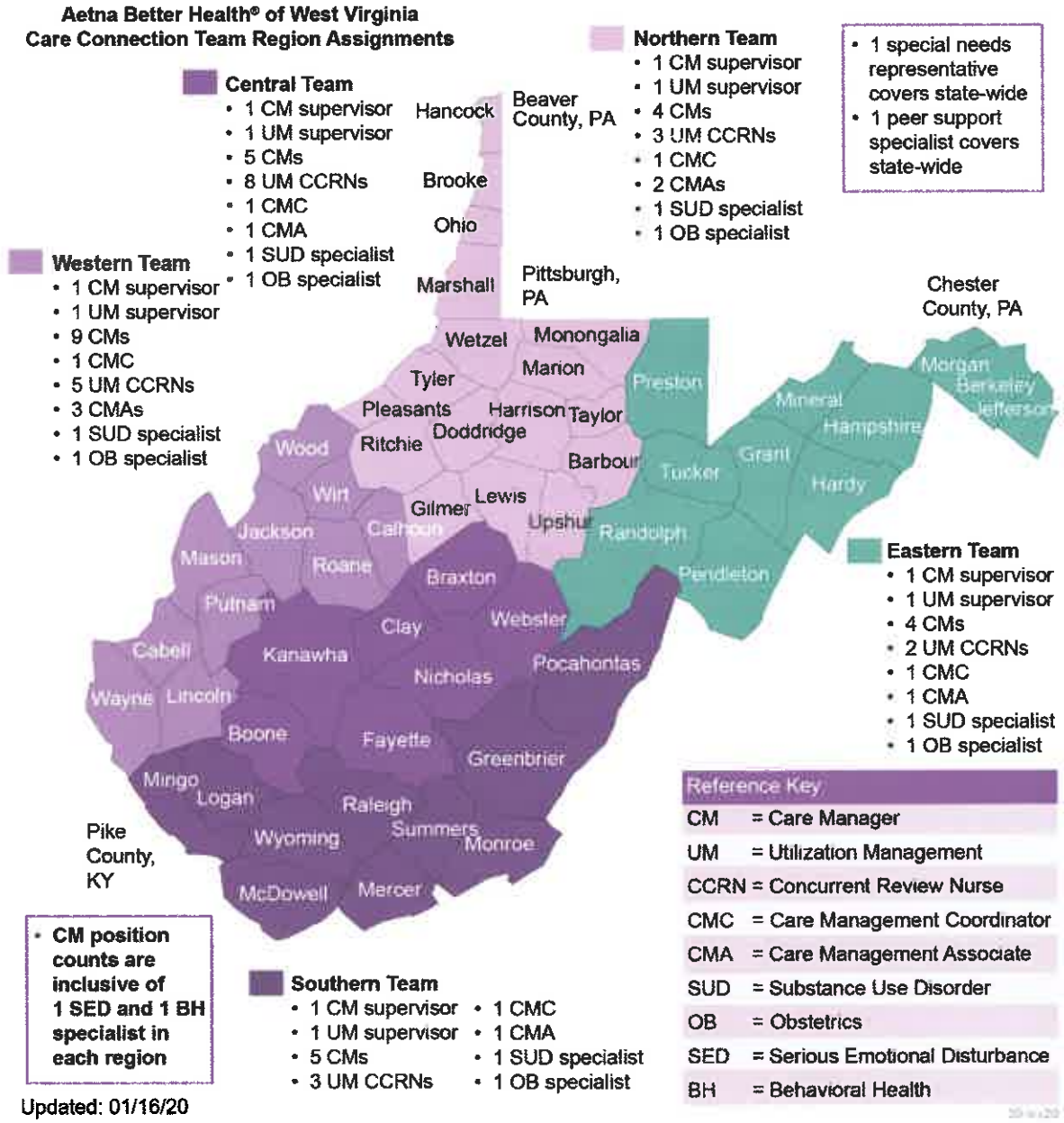


Figure 6.3.1-1: Regional Care Connection Teams
Aetna has well-established local Care Connection teams in West Virginia that are experts in regional health care needs and available services.

Table 6.3.1-1: Care Connection Team Co-Location Sites

Region	Provider Location	Region	Provider Location
Northern	• Chestnut Ridge (BH) • Weirton Hospital • Wheeling Hospital (NAS program only) • WVU Ruby Memorial	Western	• Camden Clark • Dr. James Bailes, Cabell Huntington Pediatrics • Edwards Comprehensive Cancer Center • Lily's Place • Marshall Health
Central	• Charleston Area Medical Center (CAMC) (UM and CM): Women and Children's Hospital, General Hospital, Memorial Hospital, and Obstetrics/Genecology (OB/GYN) Center • Dr. Ammar Shammaa-Women Care Clinic • St. Francis Hospital (UM and CM) • Thomas Memorial Hospital	Southern	• Beckley Appalachian Regional Hospital (BH) • Dr. Ammar Shammaa, Logan, WV • Greenbrier Valley Medical Center Mercer County • Pavilion (BH) • Williamson Health & Wellness Center (FQHC)

Embedded Care Coordinators Make a Difference—A Letter from a Provider

"Rebecca Lawrence, registered nurse (RN) care coordinator with Aetna, works within the Charleston Area Medical Center's OB/GYN Center regularly during our high-risk obstetrical clinics. Rebecca meets with the patients and builds a rapport with them that is invaluable. The CAMC OB/GYN Center provides care to a many number of patients that can and do benefit from the experience, care, and compassion that Rebecca brings to her job. Rebecca helps work with the patients and our staff to provide them with the resources they need at a time that can be very overwhelming for the patient and their families. Rebecca aids in helping patients with medication approvals, transportation issues, appointment scheduling with staff, referrals, cellphone services, housing, and any social service resources the patient may need. Rebecca's background in obstetrical nursing aids in her understanding of the type of patients we serve and what their medical needs may be. In closing, the staff here at the CAMC OB/GYN Center feels Rebecca is an integral member of the health care team and we look forward to continuing the relationship with Aetna."

Byron Calhoun, MD, FACOG
Angie Casto, MHA, BSN, RN
Jennifer DePond, MSN RN
Paul Dietz, MD, FACOG
Charleston Area Medical Center's OB/GYN Center

[CM023, CM025] Care Management/Coordination Staff Qualifications

Aetna's CCTs are comprised of seasoned health care professionals across varied disciplines who have received and continue to receive extensive training and education. **"Care**

coordinator" is the umbrella term we will use throughout the response to refer to the dedicated staff person who acts as the single point of contact for the member in the delivery of supportive or intensive care management. Care coordinators may be CMCs or nurses or LCSW clinical care managers (CM-Nurse or CM-LCSW). We employ specialized care coordinators including clinically trained OB nurses in each region, a certified wound care nurse, and 11 certified case managers. Our team members offer an array of clinical experience in pediatric, BH, oncology/hematology, neurology, nephrology, ophthalmology, cardiology, surgery, and trauma care. We are also proud of the inclusion of two certified lactation consultants in our CCTs. Three other care managers are currently training for this certification, so that we will have a certified lactation consultant in each region later this year. Each CCT also includes an SED specialist care manager (RNs or social workers who receive specialized population-specific training), a BH specialist care manager (LCSW), and a SUD specialist care manager (nurses or LCSWs) who offer expertise around regional resources and referral processes as they relate to SUD services. All Care Management staff are encouraged to complete case management certification when they are eligible. Staff qualifications and role descriptions for care coordination staff titles within the Care Management department are as follows:

- **Care management associate (CMA):** assists members with limited needs and/or low risk conditions in our Tier 1 population health care coordination program (details regarding care management tier criteria and tier-specific interventions are provider later in this response); **Qualifications:** High school diploma or General Educational Development (GED) with background check for work experience in health care settings or customer service.
- **Care management coordinator (CMC):** assigned as the care coordinator for members with moderate acuity or risk in Tier 2 supportive care management. **Qualifications:** Bachelor's degree or non-licensed master level clinician required, with either degree being in behavioral health, medical field, or human services preferred (psychology, social work, marriage and family therapy, counseling) and field work experience in health care.

- **Care manager-nurse (CM nurse):** assigned as the care coordinator for members in Tier 3 intensive care management whose primary needs relate to multiple or complex chronic conditions. **Qualifications:** Registered nurse with current unrestricted state licensure and three to five years' clinical experience. MCO and Medicaid experience preferred. Bachelor of Science in Nursing preferred.
- **Care Manager-BH (CM BH):** assigned as the care coordinator for members in Tier 3 intensive care management whose primary needs related to behavioral health conditions. **Qualifications**: One of the following behavioral health clinical licenses in the state required: LCSW-LPC–LICSW or LISAC minimum of a master's degree in behavioral/mental health or related field with three to five years' clinical experience.

We have identified opportunities to expand BH and SUD services utilizing peers. Peers are individuals with lived experience and can be extremely effective in engaging people in care, reducing the use of emergency rooms, and helping our members understand their healthcare resources. We have hired one peer support specialist to offer support primarily in the Western and Central regions where we see high rates of SUD, although they can help state-wide when requested. Given the prevalence of SUD as a contributing factor to trauma and poor health, our peer support specialist is a valuable member of the CCT, as they **possess the ability to engage and connect with members and their circles of support in a unique and meaningful way that only those with lived experience can.** The peer support specialist helps the assigned care coordinator and member in the identification of community resources and offers shared perspectives and encouragement through face-to-face visits with the member. The peer support specialist receives specialized training and coaching to serve on the CCT and participates in assessment and care planning, when requested by the member. When a member, care coordinator, and care team members identify that the peer support would be beneficial, the assigned care coordinator makes a referral to the peer support specialist. As this program continues to evolve, we are considering further expansion of peer support with the possible addition of more peer support specialists, particularly in regions of high OUD.

Our team also includes an SED project manager who has oversight over waiver management reporting, serves as a liaison for SED providers, and educates CCT members regarding the children and adolescents with SED. Additionally, our Special Needs Representative offers members assistance in applying for benefits. This role will be described in greater detail later in the response.

[CM023] Care Management/Coordination Staff Training

Aetna CMAs, CMCs, and CMs possess extensive knowledge and training across a variety of content areas, processes, and approaches. Upon hire, staff are trained both through live training sessions and through online Relias Learning Management System modules. Training topics include not only processes, but clinical models and approaches such as TIC, motivational interviewing, and ethics. Completion of initial training for new employees is tracked by care management supervisors through our training and orientation checklists. Our *Integrated Care Management Basics for Care Managers* manual is provided to new care management/coordinator employees and reviewed during the initial training phase. The manual covers topics such as the following:

- The role of the care coordinator
- The role of the interdisciplinary team includes the following:
  - Supporting providers in medical homes, assist in assuring integration of services and coordination of care, and help provide care management for members
  - Ensuring appropriate and efficient care transitions including discharge planning
  - Assessing the physical, social, and behavioral risks and needs of each member
  - Providing medication review
  - Providing member health education on complex clinical conditions and wellness programs
  - Assuring integration of primary, specialty, BH, and referrals to community-based resources
  - Maintaining frequent contact with member including face-to-face visits, email, and telephone options
  - Assisting in developing, updating, and monitoring a person-centered care plan
- Clinical guidelines for chronic conditions and other special health care needs
- Review of the Recovery Model, which focuses on the possibility of recovery, that the path of recovery is individualized, and that there is hope through recovery
- Case scenarios

- Documentation standards
- Care management policies

Other clinical content training provided upon hire includes the following:

- TIC (described in greater detail herein)
- Motivational interviewing
- Mental Health First Aid
- Family First Prevention Services Act and other federal and State policy.
- Conducting face-to-face visits
- Cultural competency
- Gaps in care
- Use of available member education materials
- Assessment and treatment of SUDs and American Society of Addiction Medicine (ASAM) criteria
- Behavioral health services
- Lesbian, gay, bisexual, transgender, and queer self-identifying (LGBTQ) community
- Addressing obesity in individuals with mental illness
- Lactation
- National Diabetes Prevention Program
- Individuals rights
- Introduction to Milliman Care Guidelines
- Improving health care quality and identification of quality of care issues
- Medical necessity
- Confidentiality
- Service excellence
- Medicaid 101
- Review of BBH and BMS policies
- Local review of State and county health improvement plans, United States Department of Agriculture local WIC/Supplemental Nutrition Assistance Program (SNAP) numbers-data and education on demographics and socioenvironmental factors
- Children with Special Health Care Needs
- SDOH resource tools including Aunt Bertha, Unite Us, and other community resource sites

Staff also receive extensive information systems trainings as it relates to the documentation and sharing of screenings, assessments, and care plans with members, providers, and others given permission by the member.

Our staff training occurs through multiple modalities to reinforce learned skills. Some trainings are provided by teleconference with live presenters, some through online trainings, and others are delivered in person at onsite trainings. All trainings emphasize opportunities for care and

community collaboration. Care coordination staff continue to receive ongoing monthly and quarterly training and assessments through our Relias (online training) offerings on a variety of topics and Aetna required compliance trainings. Care coordinators are encouraged to attend a health care summit or conference (pertinent to their background, role, and the care being coordinated) once per year and licensed staff are required to complete continuing education units as required to maintain licensure.

Aetna is leading managed care with our innovative approach to make an organizational trauma-informed care transformation. We are working with the National Council for Behavioral Health (National Council) for this cultural transformation, working with all levels of the organization including our national shared services staff, local health plan staff, and health plan providers to affect the outcomes of our members in all areas of interaction. In West Virginia, we have already made significant gains towards TIC transformation. Our Care Coordination, Member Services, and Community Outreach staff receive comprehensive and ongoing TIC training upon hire, annually, on demand through our Relias training system, and on an ad hoc basis, as new training modules are added to our trauma toolkit throughout the year. We established the training content in collaboration with the National Council. The West Virginia Aetna team was one of the first plans in the country trained in advanced coursework on TIC. We had a kickoff event with the National Council specific to West Virginia in January 2019, including a day-long training event for all staff. In total, Aetna's national Medicaid organization has trained approximately 2,500 Medicaid staff in foundational trauma training since 2018. In West Virginia specifically, 93 percent of staff in have completed the National Council's onsite TIC training and our goal is to have 100 percent trained prior by Q4 2020 (including our new Mountain Health Promise staff). We have advanced trainings scheduled for staff and providers

on February 11th, 12th, and 13th, 2020. Many providers and some representatives of BCF have registered for this training. Some of the training topics include the following:

- Defining trauma
- Prevalence and impact of trauma and ACEs
- Building resiliency and hope for recovery in the face of trauma and self-care
- Introducing TIC
- The importance of TIC for the populations served by the Aetna Medicaid organization
- Four assumptions of TIC
- Six principles of TIC

[CM024 – CM029] Care Management Hiring and Monitoring Process

Based upon our longstanding service in West Virginia, **we have a robust Care Management team already in place throughout the state that is ready to continue to provide care management activities on day one of the new contract period**. To ensure we remain adequately staffed, we continually review our staffing model and should a need for additional staff arise (and/or to address normal staff turnover), any hiring and staffing will begin immediately when the need is identified **[CM026, CM027]**. Should additional hiring occur, our intention is to have all new staff hired and beginning their training and orientation one month to six weeks prior to the go-live implementation date. Health fairs will be held throughout the state if needed, along with teleconference interviewing. Aetna has an active database of potential candidates and has access to a full support team within the Aetna Medicaid organization to assist with identifying candidates who meet position level requirements previously described **[CM024, CM025, CM026]**. This support team also assists with hiring, onboarding, and training as needed and to cover any potential deficits that may arise. Our staffing model includes training staff and mentors with extensive knowledge of this population. At this time, we anticipate we will not need to hire additional staff and estimate that staff counts will remain a total of 58 full-time equivalent positions to deliver care coordination for children and adults in MHT, WVHB, and

CHIP: 37 care managers (inclusive of OB, SED, BH, and SUD specialists), 5 care management coordinators, 8 care management associates, 1 peer support specialist, 1 special needs representative, 5 care management supervisors, and 1 manager of care management **[CM028]**. Maximum care coordinator to member caseloads ratios for each care management tier are as follows **[CM029]**:

- Tier 1 Population Health Care Coordination: 1:400
- Tier 2 Supportive Care Management: 1:125
- Tier 3 Intensive Care Management: 1:41

In addition to matching members' care needs to the care coordinator with the most relevant experience, appropriate staffing ratios are essential to a balanced and successful care management program. The staffing ratio tool we use to develop caseloads is based on workload studies that consider time elements, such as how long it takes to schedule and complete an assessment, call a member, or drive to a member's home, as well as time for case rounds with the medical director, community-based service collaboration, interdisciplinary care team meetings, personal development enrichment, training, supervision, and documentation. Supervisors review caseload ratios and case weights (which factor in the mix/numbers of Tier 2 and Tier 3 members assigned to an individual care coordinator) on a monthly basis. When a care coordinator's caseload approaches maximum thresholds (based on maximum ratios and case weights), our leadership team conducts a staffing review. Based on the results of this review, we submit a requisition to hire additional care coordinators or reallocate resources, without exceeding the maximum target ratios, in a manner that enables us to provide members the services they need in an agile manner.

[CM030] Monitoring and Evaluating Establishment of Care Coordinator/Member Relationships

Numerous care coordinator training modules previously listed (including The Role of the Care Coordinator, Motivational Interviewing, Conducting Face-to-Face Visits, Cultural Competency, and TIC) focus on the importance of care coordinators building compassionate, person- and family-centered relationships with members. The steps care coordinators take to develop these relationships will be discussed in greater detail throughout the response. In order to monitor and evaluate care coordinators' success in establishing relationships with their assigned members, care coordination leadership conduct **audits (monthly) and periodic review of tenure reports to ensure that screenings, assessments, care coordination tier identification, and integrated care plans are completed within all initial and ongoing/update required timeframes**. Audits of assessment and care plan documentation also identify whether the care coordinator is efficient and thorough in their interactions, which can indicate the degree to which they are building positive relationships with their members. Care coordinators also self-monitor timely completion of these elements through a search function in our electronic care management system that allows them to see when update tasks (such as an annual reassessment or required care plan update) are coming due or if any are overdue. Additionally, **leadership monitors the ability and success of care coordinators' establishment of relationships with their assigned members through an audit tool (which is developed with input from the Quality Management Oversight Committee) that evaluates the care coordinators' use of motivational interviewing techniques.** During the first three months after an employee is hired or after a new plan/contract is implemented, monthly audits are conducted on each employee, consisting of a minimum of three file reviews per employee. Additional audits occur as follows:

- If the employee's score is lower than ninety percent, the manager is required to review two additional records (totaling five records monthly)
- When the employee has achieved the ninety percent threshold for three consecutive months, audits are done quarterly
- When the employee has achieved an average score of ninety-five percent or higher for two consecutive quarters, audits are done twice per year

Observational reviews are accomplished by phone monitoring and/or face-to-face observation:

- Phone monitoring of at least five telephone calls using the applicable observational worksheets and/or business application system assessment tool for management staff to assess the quality of verbal exchange between the caller and the care manager
- For any staff providing face-to-face care management, one face-to-face observational visit is conducted with the care coordinator, the member, and family/supports as applicable. Additional face-to-face audit visits may be completed for any staff member at the discretion of the supervisor or manager.

Throughout all audit processes, if leadership identifies a care coordinator who is performing below expectations, a training plan is developed to help the staff member improve their knowledge and/or skills. As described above, leadership continues to ongoing audits of employees' performance to identify if training support is leading to desired improved outcomes.

Leadership also checks care management opt-in versus opt-out percentages on a monthly basis. If a particular care coordinator's opt-out rates are rising, it may be an indicator of an opportunity to improve relationship-building skills (such as motivational interviewing) and the staff member is required to attend relevant training. Finally, a care coordinator's success in establishing strong relationships with members and their guardians can be assessed through responses in member satisfaction surveys, which members complete if or when they disenroll from care management services. Any problematic patterns or trends identified through the auditing process results in additional continuous quality improvement activities to develop or enhance protocols or policies, or to provide additional training to staff.

System of Care

A high-performing SOC is a collection of integrated services and supports that help members achieve goals that are important to them without barriers or delays. The integrated services and supports may include all forms of health services, as well as housing, employment, healthy food, transportation, and other living supports to optimize resiliency and independence. **The SOC is grounded in the demonstration of TIC, culturally and linguistically appropriate services, and recovery principles.** Aetna recognizes the increasing importance of having a robust SOC strategy to serve members of complex, diverse populations. Enhancing, leveraging, and developing community-based systems of care better connects people to the treatments, services, and supports they need, when they need them. Aetna's SOC strategy addresses SDOH and health care disparities as part of the optimal approach to improving population health as well as health care utilization. The goal of Aetna's SOC framework is to reduce barriers, improve access to care, and identify and solve for any system process needs. We engage and participate in cross-sector collaboration to address adverse community conditions where people live, learn, work and play.

When we implemented services for the Mountain Health Promise contract, we hired four SOC administrators to lead our SOC efforts for that program. As we evaluate needs for the MHT, WVHB, and CHIP program, we plan to utilize three of these staff in a shared capacity for the MHT/WVHB/CHIP SOC. These individuals have extensive experience in the delivery and implementation of tailored services and supports for West Virginians. They are professional leaders who demonstrate passionate support through consultation to address and overcome systemic barriers that members may encounter during the care and service delivery. The descriptions below explain some of the functions/roles these administrators will offer for the MHT/WVHB/CHIP population:

- **The recovery and resiliency administrator**: actively participate in meetings such as rounds to ensure that member voice and choice is addressed; develop relationships with community-based organizations focused on recovery and resiliency and leverage those relationships to support members in maintaining community tenure; ensure member voice and choice is embedded within health plan operations; cultivate a recovery and resiliency environment within the health plan; participate in Member Advisory Council; work with Care Management Opioid Program Champion on initiatives which promote reduction in OUD and SUD
- **The adult SOC administrator:** conduct data analysis to identify service gaps with special attention to adults with complex needs, adult specialty populations, and SDOH; engage in cross-sector collaboration (with care management, quality, network teams) to identify and implement solutions for gaps in care; work with state and community stakeholders to support the needs of adults; identify community-based organizations that focus on supportive services for adults and educate internal departments about these resources; work with children's SOC administrator to confirm children who age out into the adult service system have needed services; promote TIC principles; participate in Member Advisory Council
- **The children's SOC administrator:** identify and outreach potential partners to enhance the service array for youth members and their families; support care management staff to identify resources to provide support to families and youth; analyze data to identify service gaps and, through cross-departmental collaboration, identify programs and strategies to resolve these gaps; attend Member Advisory Council; participate in rounds to ensure the needs of youth members are addressed

We believe that the recovery and resiliency administrator, in particular, will offer crucial support for the MHT, WVHB, and CHIP populations, especially with regard to TIC and initiatives related to the opioid epidemic. As an expert in community-based services and supports that promote holistic health, the recovery and resiliency administrator plays a key role in helping West Virginia personnel hold true to a recovery-focused perspective which emphasizes the importance of the individual in identifying their goals for wellness and health. The recovery and resiliency administrator advocates for service environments that are supportive, welcoming, and recovery oriented.

In alignment with our SOC framework, we identify and collaborate across sectors to address gaps and barriers that contribute to improved health outcomes for well-defined populations including people with complex needs or members of marginalized populations. The following departments engage in collaboration with our SOC administrators:

- Medical Management (Utilization Management and Care Management)
- Quality
- Finance
- Provider Experience
- Network
- Member Services
- Claims
- Fraud/Specialized Investigative Unit

West Virginia's state goals to deliver enhanced coordination of care and access to services, enhance quality of care, and reduce fragmentation to offer seamless continuity of care provide the SOC administrators direction on what services are needed to promote, restore, and maintain the health of members. Aetna is aware that service gaps are present, including the absence of specific services and providers, insufficient coordination of service delivery, and inadequate capacity of present services. The collaborative nature of a SOC approach allows the team to communicate systemic solutions (such as the addition of new providers, contracting of traditionally out-of-network providers, or coaching existing providers to develop new evidence-based programs) for MHT, WVHB, and CHIP enrollees, which improves access to quality services. Health literacy, SDOH, and navigating the health care system are major challenges for many of our members. As challenges or barriers are identified, most often through multidisciplinary rounds, SOC administrators assist in addressing the barrier and developing solutions so that members' experiences are streamlined, and providers can have seamless access to services for their members. SOC administrators are trained in community, local, federal, and national resources and participate in community stakeholder discussions as well as public health meetings. **Figure 6.3.1-2** depicts our integrated SOC and demonstrates our comprehensive focus on the member and their circle of support (i.e., the people the member wants to be involved from outside the health care system), primary needs, and goals.



Figure 6.3.1-2: Aetna's Integrated System of Care
Aetna's integrated system of care includes all health care and related services and supports necessary for members to achieve improved health outcomes.

Care Management Processes and Member Identification Overview

CM001	The Vendor should describe its Care management program, including, but not limited to:
CM002	Processes to organize its care management department by disease or problem type
CM003	Processes to identify members for participation in the care management program, including screening and timeliness of enrollment, risk levels, tiers, Social Determinants of Health (SDOH)
CM004	Processes and timeframes for assigning members to a care manager
CM005	Processes for identifying members for care management, or those receiving high-cost care, who would benefit from care management
CM006	Processes for how care managers will establish relationships with members, including frequency and timeliness standards after the initial health assessment
CM007	Processes to ensure that members who have specialists as Primary Care Providers (PCPs) are receiving primary care services on an ongoing basis, and interventions if adequate services are not being provided
CM008	Processes to ensure continuity and coordination of care
CM009	Processes to identify pregnant women at enrollment and on an ongoing basis
CM010	Processes for promote "early and often" prenatal care for women identified as being pregnant
CM011	Processes for Supplemental Security Income (SSI) members, if different
CM012	Processes for administering care management for both adults and children

CM013	Processes for administering care management for members with special health care needs, defined as individuals with complex or serious medical conditions
CM014	Processes for administering care management for children with special health care needs (CSHCN)
CM019	Clinical, social, or other criteria used to determine which members require care management and assignment to care managers
CM031	The Vendor should describe its protocols for addressing a member that would benefit from a care manager, including alternatives for members that do not want a care manager, members who cannot be reached, and members who have missed medical appointments.

[CM001] Upon enrollment and/or referral for care management, **all members are screened for needs that indicated they may benefit from care management.** If a member's response to initial screening meets certain criteria (to be described later in the response), they are assigned into one of three levels of care management. Aetna uses a range of screening, risk stratification, and clinical assessment tools to evaluate life adversities, acute and chronic conditions, risks, strengths, SDOH, and resilience factors to assign children and adults enrolled in the West Virginia MHT, WVHB, and CHIP program into a level of care management that meets their unique, holistic needs and addresses their particular SDOH. Our initial screening and engagement activities encourage member and circle of support participation from the beginning and are designed to understand each unique member in the context of their lives. The three care management levels into which a member may be assigned include: intensive care management (Tier 3); supportive care management (Tier 2); and population health care coordination (Tier 1). For purposes of this response, we call the treatment plan the 'care plan.' Members in Tier 1 develop care plans as needed with their PCP. Aetna care coordinators partner with members in Tiers 2 and 3 to develop a person-centered care plan that enhances their quality of life and assists them to build resiliency and maximize self-sufficiency as they achieve their individual health care goals. Care coordinators continue to collaborate with

members, their circle of support, and providers to conduct ongoing assessment, care coordination, and care plan updates. **Figure 6.3.1-3** provides an overview of our care management processes. The details of each step in the care management process overview **will** be provided following this overview figure and throughout the response.

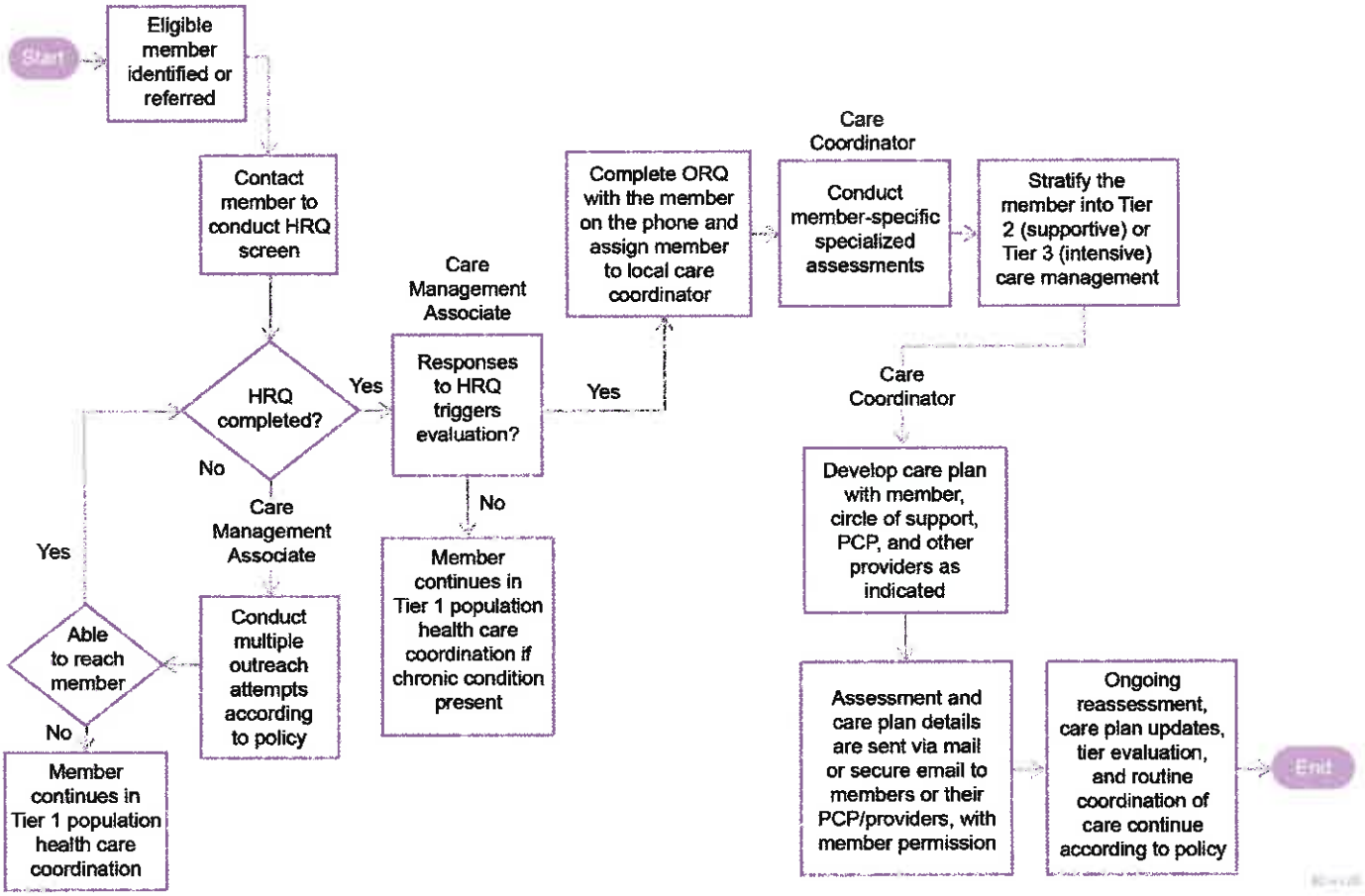


Figure 6.3.1-3: Routine Care Coordination Process Flow
Care coordination processes include screening, assessment, the assignment of a dedicated care coordinator, creation of the initial care plan, and ongoing coordination of care.

[CM002] Disease or Problem Related Care Management Organization

Aetna's CCTs are structured and organized by region, based upon membership in each region, rather than by disease or problem type. As a result, members receive care management from CCTs and care coordinators who live in the regions where they work and are familiar with

unique challenges and resources at the local level. However, we do provide condition-specific care management within the CCT as **each regional CCT includes a complement of specialized care managers** such as the OB specialist, SUD specialists, BH specialist, and other specialized care managers/coordinators who have condition specific expertise or training, as described earlier in our response relative to staff qualifications. Members are connected to specialized care coordinators who possess the expertise and education needed to address their unique circumstances and conditions. Care coordinators conduct condition-specific assessments and interventions with members based upon individual needs such as high-risk pregnancy, SUD, chronic health conditions, cancer treatment, and BH, to name a few. As care plans are developed and health goals are monitored, care coordinators evaluate whether health care interventions and services are addressing the member's specific condition or problems. Additional information regarding the assessment, care plan creation, care coordination interventions, and outcomes monitoring process is provided throughout the remainder of this response.

While the care management staffing configuration is not organized specifically by condition or problem type, **we have designed many condition-specific care management programs and interventions**, which will be described in detail throughout this response. As one example of condition-specific care management, Aetna's Diabetes Management program assists members with a diagnosis of diabetes understand the health risks of living with their condition, the benefits of adhering to blood glucose testing and prescribed treatment regimens, and elicits changes in members' behaviors, positively impacting their current and future health and wellness. Care coordinators conduct diabetes- and weight-management assessments and develop care plans to target goals related to outcome improvement with respect to diabetes indicators and

symptoms. Care coordinators are educated regarding Aetna, state, and national resources which they share with members with diabetes including our informational mailers regarding diabetes; Dining for Diabetes; Juvenile Diabetes Association; the Camp Kno-Koma pediatric diabetes camp; and ActiveHealth wellness programs, to name a few. Through our **Diabetes Collaborative** project, we have coordinated with eight different entities throughout the state to provide Diabetes Self-Management Education classes to our members. We reimburse the providers of these classes and provide a $25 gift card for members who complete the classes and have an HbA1c test. Additionally, in collaboration with the Williamson Health and Wellness Center in Mingo County (which employs CHWs), our onsite care manager works with the CHWs weekly to enroll members with chronic diseases such as diabetes into care management. The CHWs help to link patients with community services and conduct regular home visits to assist patients with medication adherence, chronic disease self-management, healthy eating, and active living goals. The CHWs receive their instructions for patient care at the weekly care coordination meetings and are in regular contact with the team nurse.

[CM003, CM004, CM005] Member Identification and Assignment to a Care Manager

Aetna employs tested processes to identify members transitioning from another MCO to Aetna or new Medicaid and CHIP enrollees assigned to our plan to conduct screening, risk stratification, and assignment to an appropriate level of care management and a dedicated care coordinator, as will be described in detail below.

Transition of Current MHT/WVHB/CHIP Members from other MCOs

Aetna's transformative vision drives our model for enhanced care coordination supporting the children and adults enrolled in MHT, WVHB, or CHIP. To identify and coordinate care for members enrolled with another MCO who are transitioning to Aetna, we follow our Transition of

Care policy and procedure to identify and assist transitioning members. Our transition plan for members with the most immediate and complex service needs is described here.

All transitions have the potential to be traumatic, and we take action to facilitate smooth and thoughtful transitions. We will work with the originating MCO and treating providers leading up to the transition of the member to obtain necessary medical records, prior authorizations, medication lists, and any additional pertinent details that we can use to discern members with immediate needs. The timeliness of obtaining these records, as documented in our Transition of Care policy, is essential to minimizing disruption in services for members that require our unwavering commitment, collaboration, and compassion. Aetna maintains the continuity and the quality of members' care and services as they enroll in Aetna plan. Aetna's activities are aimed at supporting and avoiding unexpected complications associated with these transitions and include but are not limited to the following:

- Active participation of health plan care team in identifying and adjusting the member's care and service plan for members in transition, particularly for those who need special care during the transition
- Involving applicable Aetna staff members including pharmacy, practitioners, and providers, advocates, and other health plans as necessary so that services will continue without disruption
- Monitoring transfers to minimize unnecessary complications and to foster continuity and quality of care during care transitions
- Ensuring that member has access to needed medications utilizing Aetna or the BMS pharmacy claims data

In addition to collaborating with the MCO and incorporating enrollment data provided, we utilize the following data sources to identify the service history of transitioning members with immediate and/or complex needs (such as those who are inpatient at the time of transition or those who receive multiple psychotropic medications):

- Population health platform: If a member is returning to Aetna (i.e., they have a history of enrollment with us in the past), our population health platform may offer historical

information, such as admission, discharge, and transfer (ADT) information that proves useful during transitions of care

- West Virginia Health Information Network (WVHIN): We obtain prior medical history, testing, pharmacy, labs, and other pertinent clinical information through the WVHIN

A specialized CCT comprised of interdisciplinary staff that is experienced in serving children and adults served through this procurement outreaches to high needs/medically complex transitioning members, as needed to facilitate a smooth transition. During the initial outreach conversation, the care coordinator obtains information about existing services and the member's ongoing support needs and any current concerns. The care coordinator reviews the member's person-centered care plan (if applicable), enrollment file, and any other functional assessment and health and service authorization records provided by the Department. We ensure that our care coordinators understand the impact of previous trauma and the importance of creating an environment of safety that does not cause re-traumatization. With this in mind, at each step, the care coordinator involves the member, providers, and the member's CCT in the transition process to ensure the member feels supported and heard throughout the change. Our staff facilitates the development of a comprehensive transition plan that contains clear explanation of the continuation of services and medications and explains the role of the Aetna care coordinator as the point person for transition-related questions. Our goal is to provide a seamless and welcoming transition for members. The specialized CCT makes a preliminary determination of which care management tier to connect the member to for ongoing care coordination based on available data regarding the member's historical service and claims data, assessment, and care plan information, the initial conversation with the member and their family, and our clinical tier criteria and risk stratification tool (described later in this response).

[CM005] Identification of New Members or Need to Re-evaluate Current Members for Higher Level Care Management

Aetna uses enrollment data sent by the Department to identify new members who need screening for assignment to care management. Additionally, Aetna may receive referrals from other sources, who through their day-to-day work with current Aetna members, identify individuals that could benefit from a higher or different level care management services than the level in which they are enrolled. These referral sources include the following:

- State staff from the BMS and BBH
- Providers, including primary care, BH, and specialist providers
- School-based health centers, faith-based groups, and social service organizations including Unite Us and SDOH providers, such as food banks
- Through our relationship with local retail pharmacies, community pharmacists assist in identifying members who need care management services and refer them to Aetna
- Utilization Management, Quality Management, Member Services, or other internal departments
- Alert within care coordination system upon West Virginia member discharge from inpatient stay prompting care coordinator to connect with member to assess for barriers to receiving care
- Member Services and Grievances staff referrals resulting from historical data that we assess and trend at the member level
- Community organizations such as Perinatal Partnership

Existing members and/or their guardians/families may also self-refer and directly contact our Member Services line for assistance related to care management assignment. Additionally, enrollment data, claims data, annual rescreening and reassessments, monthly surveillance reports (to include SUD diagnosis information, inpatient alerts, and historical referral information), and monthly risk stratification processes (described later) help CCTs identify when current Aetna members should be contacted and considered for a different level of care management. For example, claims reports identify members who are on antipsychotic medication and/or multiple other medications and may require a higher level of care management. In these cases, our Care Coordination staff may outreach the member and their

family to assess whether they are receiving all necessary services or need lab tests, and whether they should be referred to a higher level of coordination.

[CM003] Screening and Enrollment Timeliness Inclusive of SDOH

Upon receipt of a referral or member self-referral for care management, or notification of enrollment of any new member (based on notification via Department 834 files) Aetna begins the initial care management screening process. Aetna's automated outbound screening process is our first attempt to complete the health risk questionnaire (HRQ) screening with the member. The outbound system contacts the member to attempt to complete the screening within 90 days of notification of enrollment. We disclose to the member how we use the information gathered in screening tool. The HRQ is available in English and Spanish and can be completed via multiple avenues based on member and family needs. In addition to completing the HRQ through contact by the outbound automated system, HRQs may be completed in person, or via printed or web-based forms. Further detail regarding domains evaluated by our screening tools and processes is provided later in the response.

The HRQ screening process includes questions related to SDOH and allows for initial and immediate 1) determination that the member does not require care management, 2) stratification to Tier 1 population health care coordination, or 3) indication of the need for additional assessment to determine whether referral to Tier 2 (supportive) or Tier 3 (intensive) care coordination is appropriate. All members providing positive responses to any initial screening question on the HRQ, and who may have multiple chronic conditions, SDOH barriers, or other special health care needs, receive further screening via the outreach questionnaire (ORQ). Immediately following completion of the HRQ through the outbound call process, these members are warm transferred to a care management associate for immediate additional ORQ

screening and assignment to a care coordinator who will later complete the health care equity (HCE) contact event, health needs assessment, and stratification into the appropriate care coordination level (2 or 3). Members who hang up during the warm transfer process appear on a report care management uses to identify those who need follow up to complete the ORQ. Members who were matched with Tier 1 population health care coordination after completion of the HRQ are given information on how to reach out to care management and the number to call if they need assistance. They will receive other care coordination intervention as described later in this response.

To maximize the number of members completing the initial HRQ screening process, Aetna uses multiple telephonic and written engagement strategies as well as in-person navigation for those new members requiring additional support. Aetna makes five attempts to contact the member by phone, each occurring on different days and different times to improve the probability of contact and completion of screening. After these attempts, Care Management staff sends a letter to the member stating that the telephonic outreach attempts have been unsuccessful and invites the member to contact Aetna to complete the screening. If the member does not contact us, Care Management staff review the claims management system, including the call-tracking notes and member records, to identify another means of reaching the member. Our regional CCT teams also work with Utilization Management staff and local hospitals for our adults, children, and youth discharged from an inpatient setting to identify member contact information in order to complete the screening. Care Management staff use medical, BH, and pharmacy claims as well as ADT data from WVHIN to identify contact information which may improve success in reaching the member to complete the screening. Additionally, care management staff has access to our CVS retail pharmacy member contact information in our **Engagement**

Dashboard, a database of phone contact information for Aetna members who utilize CVS for their prescriptions. We are also implementing in-store engagement campaigns that notify CVS pharmacists to have a conversation with a member about a gap in care. For example, if an Aetna member who presents at the pharmacy for a prescription is someone we have been unable to reach to complete an HRQ or annual care management assessment, the pharmacist can reinforce the importance of the screening or assessment and provide the member with the phone number to Member Services to request to speak with a care management representative. The pharmacist could also document interaction notes and the best day/time for the member to be reached and send the information back to Aetna to increase the likelihood of care management engagement.

With multiple entry points, data review, and member contacts, we maximize opportunities to engage members to complete HRQ screenings within 90 days and conduct outreach to those missed through initial outbound screening. Aetna reaches out to 100 percent of members and has established several additional practices to increase screening completion success via multiple points of access, including the following:

- **Member portal:** Members may complete a self-assessment via a link in our website which provides condition specific recommendations and education in response to specific member answers within the assessment; the Care Management team receives a report of completed self-assessments and members with an identified need are outreach for further assessment.
- **Member services:** Member Services representatives may identify, through conversations with members, the potential need for the member to complete screenings or further discuss care management service options; in these cases, Member Services will warm transfer member calls (with member agreement) to Care Management staff for completion of the screening to determine if they may benefit from a higher level of care management.
- **Aetna mobile application**: We are evaluating the possibility of enhancing our mobile application to allow members to complete the HRQ through our secure mobile application. The HRQ data would feed directly into our electronic care management system. If it is determined we will add this functionality, it would likely be implemented in 2021.
- **HRQs completed in the community:** The HRQ tool is available for completion with embedded care coordination staff and at other provider locations.

[CM003, CM005] Risk Stratification

Consolidated Outreach and Risk Evaluation (CORE™): Proprietary and evidence-based, CORE is a stratification tool that uses time-tested analytic methods honed for more than 10 years. CORE contributes to member stratification from internally developed algorithms based on population data and our clinical and informatics expertise. CORE includes census track and ZIP code data to incorporate social determinant elements at the population level in its predictive modeling. CORE, in conjunction with the data sources described below, determine each member's potential risk level (please refer to the bullet points below in conjunction with **Figure 6.3.1-4):**

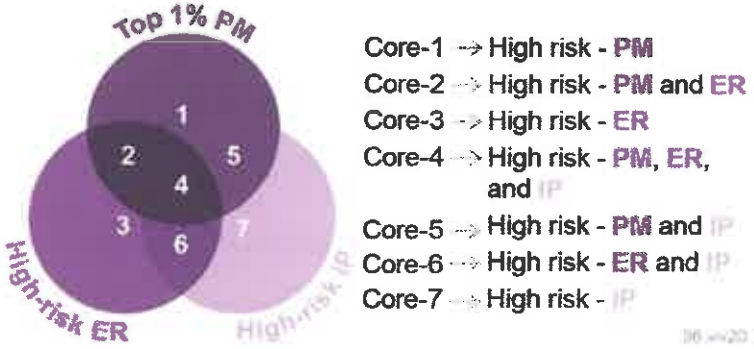


Figure 6.3.1-4: Aetna's CORE Model
CORE allows Aetna to identify members with a potentially high-risk for costly utilization who may benefit from enrollment in care management.

- **Predictive Modeling (PM) General Risk Score**: members in top one percent of population based on medical and BH diagnoses, medical service utilization, and pharmacy use
- **Emergency Room (ER) Risk Score**: risk of an ER visit within the next 12 months
- **Inpatient (IP) Admission Risk Score**: risk of an IP admission within the next 12 months

CORE has identified that 2.6 percent of our West Virginia enrollees fall into CORE level 4 (highest risk), as compared to 0.5 percent in another Aetna Medicaid health plan with the next highest percentage of members in this category.

Aetna uses several indicators in addition to CORE, including the HRQ, ORQ, additional assessments, surveillance or referrals, concurrent review, and real-time medical and pharmacy utilization data to ensure that members are receiving care management at the appropriate intensity and tier level. We run the model for our entire population monthly and the results of CORE stratification are sent to a work queue in our electronic care management system, which

is monitored by care coordinators and their supervisors. CORE's internal algorithm communicates in the work queue when a member's risk level has changed, which informs care coordinators and supervisors when a member might possibly need further assessment to determine if a different level of care coordination is appropriate. For example, if a member is identified with CORE level 4 (the highest, most intensive risk stratification), the care coordinator will modify the member's tier level to level 3 for intensive care management services and will outreach the member to initiate services in alignment with expectations for that tier (described later in the response).

Predictive Model of CORE

CORE results are predictive in multiple dimensions:

- The ER model has a positive predictive value of 72.1%, meaning that 72.1% of the time, the predicted ER utilization occurs in the next 12 months with a positive predictive value of 95.4%
- These factors, coupled with our utilization management and quality management surveillance strategies, enable us to assign members to the most appropriate levels of care

Rising risk model: Because Aetna believes in a prevention and early intervention approach wherever possible, we have developed a rising risk model to identify children and youth with key risk indicators and health outcomes that may be impactable by prevention and early intervention of trauma-informed practices, approaches, and care. This practice allows the care coordinator and the member's care team to intervene at an earlier point with newly enrolled members to provide increased support and services to avert potential traumatic events or utilization of more restrictive or intensive levels of care. **Aetna's rising risk model uses 28 different measures to stratify and score members age 17 and under** including measures around specific BH disorders, opioid use, physical/sexual/psychological abuse, self-harm claims, comorbidities, risk stratification score, engagement in care coordination, PCP assignment, frequency of changing PCP over the course of a year, total medical spend, ER utilization, pregnancy, justice system

involvement, sexually transmitted disease diagnoses, household opioid use, household self-harm claims and household physical, sexual, or psychological abuse. Weighted scoring is assigned relative to specific diagnoses, treatments, or services. Using this method, the care coordinator can rapidly identify members and who are at elevated risk that may need to receive services at a higher tier of care management. Once a member is identified for rising risk, the care coordinator will outreach the member to further assess the situation and determine the next best course of action. This may include assignment to a higher care management tier if warranted, based upon review of all available information including the rising risk score and the updated assessment. Members with rising risk may need other types of increased assistance such as help with obtaining transportation or addressing needs related to upcoming surgeries. While our current rising risk analysis activities focus on children, we are expanding this model to adult populations with a condition-specific focus.

[CM005] Monitoring members with high physical or behavioral health needs/high-cost care: Aetna is committed to care management for children and adults with high needs/high-cost care. Members are identified within this category based upon indicators found in high-cost reports and screening data, presence of multiple behavioral diagnoses, recurrent ER visits, complicated medication regimens, and/or social isolation, to name a few. Members with high-need/high-cost care receive coordinated and comprehensive monitoring through care management that emphasizes member- and family-centered care and strengths-based approaches. These strengths-based approaches are integral when supporting members with high needs as it is recognized that these members may have experienced difficulties with accessing and receiving care due to a variety of variables and thus need to be actively engaged in the care delivery process to drive optimal health outcomes. Our approach focuses on cultural sensitivity, peer-to-peer support,

coordinated care, and goal setting. Thus, member care is monitored closely to ensure the CCT is apprised of any changes in status and need for more or less supportive services. Before final determinations and/or changes are made, the care coordinator and the member will collaborate to discuss all potential options in a collaborative fashion. The care coordinator also works with the member to discuss progress toward care plan goals, address any barriers they may have, and additional individual needs will be assessed informing whether more or less intensive services and supports are needed based on the member's feedback. We leverage our relationships with community organizations to stay connected to members during critical times ensuring a seamless system of care. For example, we have Care Management staff embedded in 10 hospitals and BH facilities who can convene with all collaborators, the member, and the member's supports, to ensure the best plan is in place.

[CM003, CM006, CM019] Care Management Tiers and Frequency of Contact

Based upon HRQ screening outcomes (inclusive of clinical and SDOH information to be described later), risk stratification predictions described above, as well as assessments (described later), Aetna uses a person-centered approach to assign eligible members to one of three care management tiers that matches their individual needs. **Table 6.3.1-2** depicts the clinical and SDOH criteria for each care management tier **[CM019]**.

Table 6.3.1-2: Clinical Criteria for Care Management Tiers

Care Management Level, Ratio and Staff Type	Clinical and/or SDOH criteria
Intensive Care Management (Tier 3) CC to member ratio: 1:41 Care Coordinator Staff Type: CM Nurse, CM LCSW	• Individuals with multiple complex chronic conditions, comorbidities, or co-occurring conditions, special health care needs, medically complex • Individuals with three or more ER visits or previous BH inpatient admissions • Pregnant women with a history of substance use or who are currently using substances • Pregnant women with current or historical high-risk pregnancy

Care Management Level, Ratio and Staff Type	Clinical and/or SDOH criteria
	• Infants with NAS • Children and young adults with abuse and/or trauma histories with significant SDOH needs or with other complex diagnoses • Adults and adolescents who are homeless or have a history of residential instability (four or more residences over the past year) • Children with SED • Individuals with HIV/AIDS, cancer, chronic renal failure, and other chronic complex conditions
Supportive Care Management (Tier 2) CC to member ratio: 1:125 Care Coordinator Staff Type: Care Management Coordinator	• Moderate acuity, not at risk of crisis • Individuals with ambulatory care-sensitive conditions or a disease management condition (e.g., asthma, chronic heart failure, chronic obstructive pulmonary disease, diabetes, or depression) • Referrals from within the plan or a provider that indicates care coordination or service needs and/or readmission risks
Population Health Care Coordination (Tier 1) CC to member ratio: 1: 400 Care Coordinator Staff Type: Care Management Associate	• Individuals with limited health care needs • All members with chronic conditions needing ongoing surveillance and support identified for care management and not enrolled in Tier 2 or Tier 3 • Members able to self-manage condition(s) • Low-risk pregnant members • Members with identified SDOH in need of education and resources • Member showing improvement who moved from Tier 2 to Tier 1

The frequency and intensity of care management interventions differ depending on the needs of the member and the care management tier to which they are assigned. **[CM006] Table 6.3.1-3** outlines the minimum frequency of contact expectations and services provided in each care management tier and demonstrates the various activities that promote the building of relationships between care coordinators and their assigned members. These interventions are tailored as needed to address each individual's unique circumstances.

Table 6.3.1-3: West Virginia MHT/WVHB/CHIP Tiers Contact Frequency and Intervention Types

Care Management Tier	Services Provided
Intensive Care Management (Tier 3)	• Face-to-face visit offered upon enrollment in care management and quarterly thereafter based on member needs, preferences, or change in condition • Comprehensive bio-psychosocial assessment including BH, substance abuse, and functional screening within 30 days of enrollment • Condition specific assessments for physical and BH within 30 days of enrollment • Case formulation/synthesis (summary of the member's story) • Integrated care and service planning, including covered and wraparound services • Chronic condition management provided by a clinician • Monthly member contact and care plan reviews and updates based on progress toward prioritized goals and communication of the care plan with the member, PCP, and others of the members' choosing, including barriers to care plan • Prioritized goals reflect issues identified in the assessment and documentation includes the supporting rationale for goal selection. • Annual re-assessments and based on member needs or as indicated by a change in condition. Interval assessment completed every 30 days. • Complex clinical and psychological care coordination
Supportive Care Management (Tier 2)	• Face-to-face visits, as indicated or required by contract • Condition specific assessments for conditions of focus every 90 days • Biopsychosocial, person-centered care plan which includes activities for chronic conditions, and service plans every 90 days • Chronic condition management support and referral to a clinician for clinically based needs associated with the condition(s) • Coaching on the management of conditions and issues and self-care • Encouraging members to communicate with their care and service providers • Education on disease process, self-management skills, and adherence to recommended testing and treatment • Quarterly (minimum) care plan review with discussion of goals and progress toward achieving them, revisions, and communication of updated care plan with the member, PCP, and others at the request of the member • Member contacts as clinically indicated by the member's needs, change in condition, or CM's judgement (every 90 days at minimum) • Annual re-assessments and based on member needs and as indicated by a change in condition

Care Management Tier	Services Provided
	• Care team coordination informed and supported by health plan-based multidisciplinary case as indicated
Population Health Care coordination (Tier 1)	• HRQ upon enrollment and annually thereafter; Krames family planning materials • Low-/no-risk pregnant members: quarterly screening to identify risk factors • Special populations: monitoring/tracking per state requirements • Aetna will educate members and their caregivers on how to contact the health plan should needs arise prior to outreach • Health education mailings

[CM004] Assignment to a Dedicated Care Coordinator

The thoughtful matching of a member to a dedicated, regional care coordinator serves as the foundation for the building of rapport and successful condition-focused care planning and ongoing coordination. **The care management associate, upon completion of the ORQ during the initial screening phone call, immediately identifies the most appropriate care coordinator to assign the member to,** and either warm-transfers the member to that care coordinator or arranges to have the care coordinator call them back, whichever the member prefers. In either case, the CMA provides the member with the care coordinator's contact information. Additionally, the CMA explains the care coordinator's role and what the member can expect to see happen next as care coordination continues. The CMA ensures the assigned care coordinator has all the screening and other preliminary information obtained during the initial screening contact process.

Due to Aetna's existing care management footprint in West Virginia, which has developed over many years, we possess significant expertise in the challenges and needs of West Virginia communities at the regional and local levels. As a result, **the CMA assigns members to care coordinators who work and live in the member's community and who have contacts with**

local partners and providers to coordinate care. The assigned care coordinator is knowledgeable of the health disparities of the region. Additionally, members are paired with care coordinators whose expertise, credentials, and training are aligned to the clinical and social needs of the member, as described earlier in our staff qualifications explanation. The CMA who initially assigns the care coordinator also utilizes their knowledge of tier based clinical criteria as well as the relative current caseload sizes of available care coordinators when they assign care coordinators. The CMA considers all these factors when assigning the 'most appropriate care coordinator.' For example, children that determined to have medically complex conditions, or infants with a diagnosis of NAS, are paired with a local registered nurse care manager and placed in intensive care management. Members with a BH diagnosis or BH claims are paired with a licensed BH care manager who works in their region, and those with SUD will be connected to a SUD specialist care manager in their region. Care management supervisors monitor care coordinator assignments and identify and resolve potential mismatched assignments through assignment to another care coordinator.

[CM006] Processes Care Coordinators Use to Build Relationships

The established expectations for the frequency of care coordinators' contact with members based on their assigned care management tier (previously described) foster the development of relationships between care coordinators and their assigned members. However, relationships are strengthened not just by completing the required number of contacts, conducting assessments, and helping to develop care plans, but through the quality and way in which these interactions occur. Care coordinators offer active listening, face-to-face visits, and collaborative partnership to members in their journey to better health as they seek to understand the member's worldview and experiences. Care coordinators are trained in

motivational interviewing, TIC, person-centered planning, cultural competency, and resiliency, all which encourage the use of member-centric approaches during the assessment and care planning process that result in the creation of caring and meaningful professional relationships. Care coordinators actively engage the member to encourage their continued involvement in achieving health and life goals and maintain positive relationships by demonstrating respect for the member's preferences and cultural perspective. Care coordinators' commitment to follow through with the member and their care team conveys to members that their care coordinator is someone they can trust to be an advocate in their care.

Making a Meaningful Connection with an Aetna Member

Linda[7] is an Aetna member with type 2 diabetes, atrial fibrillation, asthma, chronic obstructive pulmonary disease, hypertension, urinary retention with frequent urinary tract infections, essential tremors, morbid obesity, depression, and anxiety. Linda was assigned to care management due to her frequent utilization of the emergency room (ER) and multiple chronic conditions. For many years, Linda had been a caretaker of other family members and reported to her care manager that she felt she had "let myself go." When the care manager first met Linda, she had a PCP, but was not attending appointments, nor was she connected with any specialists. Linda stated she did not feel that anyone cared about her. When the case manager assured Linda that she cared about her, Linda was genuinely taken aback that someone she just met wanted to help her and was concerned for her wellbeing. Knowing that someone cared about her gave her the motivation and confidence to take the first steps towards focusing on her health. Linda's case manager assisted her with establishing care with multiple specialists, including: a cardiologist, neurologist, urologist, psychiatrist, and psychologist. Linda's case manager arranged transportation reservations for her appointments and helped her create lists to track her appointments. At times when Linda felt overwhelmed, her care manager offered emotional support. Linda now attends her appointments, takes her medications consistently, and has not gone to the ER again since establishing relationships and services with her specialists. She has lost over 100 pounds, no longer requires medication to treat diabetes or hypertension, has greater self-confidence, and has increased her mobility to the point where she can work in her yard. She describes her care manager as her "Aetna friend" and vows to continue to manage her health.

[7] Not her real name

[CM008] Processes to Ensure Continuity and Coordination of Care

The assigned dedicated care coordinator acts as a single point of contact for the member and their identified circle of support. The care coordinator is responsible for coordination of care for all necessary physical health, BH, functional, and wraparound social support services to promote improved health outcomes and member quality of life. While the assigned care coordinator has primary responsibility for care coordination, they work in close contact with the member's PCP or medical home, who also has a leadership role in the care planning and coordination process. Additionally, they communicate and coordinate with other providers involved in the member's care such as healthcare specialists, school representatives, community organizations, agencies that address SDOH, CSHCN, and pharmacies. Continuity and coordination of care activities are monitored and evaluated by CCT leadership as described in our response to **CM030**. Continuity and coordination of care is delivered based on member need and care management tier level. Examples of care coordination processes are described in the following narrative.

Facilitation of Interdisciplinary Care Team Meetings

Care coordinators facilitate Interdisciplinary Care Team (ICT) meetings (for members with complex medical conditions who have established an ICT) to ensure that all members of the care team (as identified and permitted by the member) are able to provide input in the care planning process, and that they remain informed regarding the member's progress or when barriers or new concerns arise. During these meetings, the care coordinator supports the member as the lead voice, while engaging the expertise of other medical and BH providers and stakeholders who participate on the team. These meetings are critical for reviewing and updating the member's goals, confirming services are being delivered and attended as expected, and evaluating whether the member's overall health is improving.

Assistance in Scheduling Appointments and Appointment Reminders

Care coordinators assist members in Tier 2 and 3 care management in scheduling ongoing appointments, if needed. CCT staff can enter task reminders in our electronic care management system regarding required appointments that are coming due, as well as reminders regarding scheduled appointment dates. We also work with the West Virginia Primary Care Association to ensure that PCPs understand the importance of informing the CCT when a member has missed an appointment. CCT members may contact the member following missed appointments to assist in rescheduling. Members enrolled in Tier 1 care management may receive reminders about important health screenings via mailers and collaborative community events. A more detailed description of activities to address SDOH and connect members to community resources and services is provided later in the response.

Integration and Coordination of Behavioral Health Services

The care coordinator and CCT also consults with our local BH medical director, Dr. Frank Angotti III, MD, to offer specialized coordination, as needed, for any members with BH needs. For example, the BH medical director may suggest beneficial treatment options that can then be proposed to the member's PCP, BH providers, or patient-centered medical home. If needed, a telephone conversation between the BH medical director and PCP or BH provider can occur.

Assistance with Pharmacy Needs

Care coordinators and the CCT play a critical role in working with members and providers to ensure coordination for pharmacy needs and medication management, including coordination related to psychotropic medications. The care coordinator completes medication reconciliation with the member by accessing the Department's Rational Drug Therapy and preferred drug list. The care manager can assist the member with medication questions, issues, or concerns by reviewing and contacting DXC Technologies Help Desk regarding any prescription questions.

For providers with authorization questions, the care coordinator can contact Rational Drug Therapy.

[CM007] Oversight for Members with Specialists as PCPs

Aetna respects the importance of member voice in the selection of a PCP. It is critical that members have confidence in their selection of this critical provider. In the event that a member elects to have a specialist perform as their PCP, Aetna recognizes the specialist as a PCP in our data and electronic care management systems, and they are outreached by the Aetna care coordinator for involvement in care planning, just as non-specialist PCPs are. If the specialist is new to performing the functions of a PCP role, we monitor them through gaps in care reports for HEDIS measures that need to be met and review any member complaints on appointment access or practitioner behavior. We provide ongoing support and monitoring through the care coordination process and use the same interventions we utilize for non-specialist PCPs who are not providing adequate services. This may include resolution through care coordination and planning discussions, involvement of their provider relations representative, or a quality of care referral, to name a few.

[CM009 – CM014] Population-Specific Processes

While many elements of care management processes are standardized for all member populations, Aetna does utilize specialized processes for identification and care management of members in certain populations groups.

[CM009, CM010] Prenatal and Maternal Care Management

Timely and high-quality prenatal care is critical for both mothers and newborns. Beginning prenatal care within the first trimester and receiving the recommended number of prenatal care visits is essential to reducing the likelihood of maternal complications and premature deliveries. Aetna offers prenatal and maternal care management interventions that encourage regular

prenatal care, address high-risk pregnancy concerns, and provide postpartum support to foster positive health outcomes for moms and their infants.

[CM009] We emphasize early identification of pregnant women so we may engage them in prenatal care and provide more intensive care management to those with potentially high-risk pregnancies. We use mechanisms such as the HRQ, trimester screeners, prior authorization information, prenatal claims reports, pharmacy data, and direct referrals from providers, community-based organizations, and Member Services staff to identify pregnant women early at enrollment and during our ongoing service delivery of members. Our electronic care management system includes a flag for pregnant women, so newly assigned care coordinators are aware of the change in the member's health status. We stratify pregnant women with a history of or current SUD and those with current or historical high-risk pregnancies into our intensive care management (Tier 3) program. Pregnant members in Tier 1 and 2 care management also receive pregnancy-specific care management interventions. Prenatal and postpartum interventions will be described throughout this response.

[CM010] Babies of mothers who do not get prenatal care are three times more likely to have a low birthweight and five times more likely to die than those born to mothers who do get care, according to the U.S. Department of Health and Human Services[8]. In 2018, West Virginia's preterm birthrate was 11.8 percent, which correlates to a grade of F. Additionally, in West Virginia, the preterm birth rate among African American women is 22 percent higher than the rate among all other women.[9]

We promote healthy pregnancies by encouraging pregnant members' early and frequent use

[8] Early Prenatal Care Important to You and Your Baby," Johnson Memorial Health: accessed January 21, 2020; http://blog.johnsonmemorial.org/prenatal-care-important-for-you-and-baby
[9] "2019 March of Dimes Report Card": accessed January 21, 2020; https://www.marchofdimes.org/mission/reportcard.aspx

of prenatal care. Upon identification of the pregnancy of an enrolled member, the member's provider completes the Prenatal Risk Screening Instrument (PRSI) during the first prenatal visit with the member. The results of this screening are sent to the Aetna care coordinator via fax or mail. To encourage providers to complete the PRSI, we offer a $25 incentive. The care coordinator uses the information in the PRSI to inform care planning strategies. Members in supportive or intensive care management are outreached by their care coordinator to complete additional pregnancy-related assessments (such as the perinatal assessment). The care coordinator collaborates with the member to begin the care planning process to ensure all of the member's needs are identified, to educate the member on the importance of attending prenatal visits, and to ensure prenatal services are scheduled.

All pregnant members receive a copy of Aetna's "Healthy You, Healthy Baby, A Guide for Moms and Families." This comprehensive document offers education regarding prenatal care, delivery, and how to take care of a newborn, including information regarding recommended well-child visits.

Pregnant members with high-risk pregnancies are typically be assigned to an OB specialist care manager who is skilled not only in offering pregnancy-related education but in offering support to first-time moms who may feel overwhelmed or anxious regarding pregnancy. Our care managers offer reassurance and compassion to promote healthy pregnancies and healthy babies. Pregnant members with historical or current SUD may enroll in our NAS care management program called Moms and Babies, which is described in greater detail later in the response where we discuss prescription drug abuse. Pregnant members with low-risk who are assigned to Tier 1 population health care coordination receive educational mailings regarding prenatal care services and pregnancy-related topics. We conduct trimester screeners with these

members as well to evaluate for any changes which might suggest a higher level of care management is necessary.

Our Healthy Pregnancies, Healthy Babies program aims to increase the timeliness of prenatal and postpartum care by two percent, year over year. This program encourages pregnant members to make early and frequent prenatal visits and to follow through with needed postpartum visits, to have the healthiest pregnancy and birth possible. It is supplemented with the availability of the following value-added benefits:

Cribette® Distribution for Pregnant and New Moms

Since 2016, Aetna has distributed 1,321 Cribettes to pregnant and new moms participating in our specialized programs for pregnant members and new moms.

- Cribette® (portable crib) for pregnant members who attend six prenatal visits; these portable cribs discourage or reduce the likelihood of co-sleeping, which can be a contributor to infant fatalities;
- $50 gift card for a postpartum visit between 7 and 84 days after delivery
- Pregnant enrollees receive up to two preventive dental visits

Women enrolled in the NAS Moms and Babies program receive the following incentives:

- Cribette or baby carrier to pregnant members who enroll in the NAS program for moms and babies upon delivery
- Program graduation gift

Aetna utilizes a regionalized model to impact disparities related to maternal health and birth outcomes in each identified CCT region and individually with members. Throughout all counties in the state of West Virginia, Aetna has implemented the following interventions and value-added services to address disparities in each region or identified member need:

- OB case managers embedded at seven OB practices, inclusive of Lily's Place, which includes NAS programming components
- One-on-one consultation with lactation specialists
- Care coordination through baby's first year for the following:
  - Mothers with high-risk pregnancies or SUD during pregnancy
  - Neonatal intensive care unit babies or babies with chronic or complex conditions

- Text4baby messages to keep mom and baby healthy, for those who accept text message communications
- Up to two preventive dental visits during pregnancy and a dental hygiene kid
- Trimester risk screening assessments inclusive of assessment of the use of smoking tobacco and referral to the West Virginia Quitline as appropriate; smoking cessation education
- Distribution of welcome packets to pregnant members with information on how to enroll in the WIC program for access to subsidies related to food products

In addition to these activities, we utilize targeted programs to engage pregnant members in prenatal care and education. Targeted programs address teen pregnancy, maternal/family wellbeing during pregnancy, and awareness programs to help new parents be thoughtful caregivers to their newborns.

Teen pregnancy: **Aetna provides care to teens who are pregnant through care coordination co-located with three high-risk obstetric providers in West Virginia.** This team provides both physical care and case management. Together they offer education to the teen and her support system. Comprehensive assessments are conducted to determine not only the physical and behavioral health of the teen but also environmental, educational, social, and economic situations. These assessments set the foundation for additional referrals, including transportation, specialists, inpatient residential, and further BH services. Aetna collaborates with Crittenton Services, the only residential program in the state for pregnant teens or teen girls who are parenting. Providing a continuum of BH services with residential care for girls 12 to 21 in 28 counties, Crittenton leads West Virginia in providing TIC to vulnerable young women who are pregnant. Aetna provided funding for foster families of girls in residential treatment for a weekend retreat to assist in preparation for the girls and their babies to return home. Crittenton therapeutic staff created the Family Integration in Treatment (FIT) program to improve outcomes for girls (many with babies) that are discharged from congregate care and return to their families, kinship care, or foster care. For girls in the residential program, distance, custody

issues, and resources limit the amount of contact with their families during the residential stay. FIT brings families to the residential facility for a weekend of intensive therapy and aftercare planning, at no cost. This program will be available to all Aetna Medicaid and CHIP members.

Supporting maternal/family wellbeing during pregnancy: Aetna care coordinators also work closely with Right from the Start and the West Virginia Healthy Start/Helping Appalachian Parents and Infants (HAPI) program. Pregnant members are referred to Right from the Start by Aetna care management staff, and those who are eligible are educated on the HAPI program. **HAPI services are targeted to improve maternal wellbeing** during pregnancy, prenatal care, postpartum, and during the inter-conceptional period. HAPI strives to offer services, education, referrals (e.g., for postpartum depression or maternal dental care), resources, and support to the whole family—this includes fathers/male partners of active HAPI participants. The Fatherhood Initiative focuses on providing information and support to fathers through the Fathering in 15 program. This program was developed by the National Fatherhood Initiative and is a free tool that allows fathers/male partners of active HAPI participants to access information to further their understanding of parenting and fathering skills.

Educational campaigns for new parents: Aetna is the only MCO in West Virginia to train all of its care coordinators in the Safe Sleep awareness campaign. We collaborate with Our Babies: Safe and Sound on the Safe Sleep campaign to provide education to members regarding safe infant sleep positions and offer onesies to parents that say "This Side Up" as a reminder of proper sleep positioning. As a value-added benefit, we offer Cribettes to offer portable safe sleep environments. Additionally, all our care coordinators are trained on the Keep Your Cool material, which offers education regarding the careful handling of babies and self-calming techniques for parents to prevent shaken baby syndrome.

OB Specialist Care Manager Embedded within MAT Program Helps Aetna Member

Rachel[10] was using Fentanyl and heroin when she found out she was pregnant. She began attending MAT services in the Logan area and was enrolled in Aetna's NAS/Moms and Babies care management program. Rachel's care manager connected her to needed services and resources including Right from the Start, a cribette, the Gabriel project, LogistiCare, and Heart and Hand. Allison delivered a full- term baby girl. After weaning successfully from Methadone while inpatient in the Thomas Memorial Hospital NAS/BabySteps unit, Rachel and her baby were discharged home with Rachel's grandmother. At last contact, Rachel reported her baby is thriving at home, is gaining weight, meeting milestones, and continues to work with RFTS services. Rachel continues in her weekly appointments and therapy in MAT program and has successfully maintained her sobriety.

[CM011] Processes for Supplemental Security Income (SSI) Members

We utilize our standard care management processes described throughout this response for members with SSI. However, we do offer a **special needs representative** who meets face-to-face with members that may qualify for SSI to help them complete SSI applications. Members are connected to this representative through referral by UM, CM, providers, and Member Services. The special needs representative offers both face-to-face and telephonic assistance to members to complete applications. They also provide education to Aetna Care Coordination staff to ensure they understand SSI eligibility criteria and can more readily identify which members should be referred to the special-needs representative for assistance.

Aetna's Special Needs Representative Provides Critical Support for Members Applying for SSI

Ellen[11] was hospitalized twice for pneumonia and was placed on continuous oxygen. She had struggled with substance use and had recurring severe yeast infections in her spinal column as a result. She had experienced mental health challenges, including bipolar disorder, and was homeless. She was offered short-term shelter at her father's home. Ellen's care coordinator referred her to Aetna's special needs representative (SNR) for assistance in applying for disability benefits. The SNR spent extra time with Ellen to gather all the necessary information, which at times was difficult for Ellen as she could not recall or find key information and often became frustrated with the process. In addition, several medical setbacks leading to ER visits

[10] Not her real name
[11] Not her real name

and a hospital admission occurred during this time, causing delays in her application and interview process. Ellen authorized the SNR to be her non-attorney authorized representative so the SNR could speak on her behalf during the SSI application process, participate in interview proceedings, and ensure all necessary paperwork was submitted. As a result of these efforts, Ellen was approved for SSI with back pay for months spent in the application process. She is now financially independent and able to obtain housing. Ellen says that her health will improve now that she will be able to rest in a bed instead of on a couch. She stated that the relief of not feeling like a burden to her father will also relieve a lot of stress and anxiety. Ellen continues to work with her care manager to coordinate care and substance abuse treatment.

[CM012] Processes for Administering Care Management for Both Adults and Children

The care management processes described throughout this response apply to both adults and children, except where explicitly stated otherwise. However, we do offer specialized, age-based care management interventions.

Program for At-risk Youth: Aetna defines rising risk, or at-risk youth as minors, 17 years of age or younger, who have received three or more treatments or services for high-risk diagnoses or behaviors. These members may be at risk for long-term physical health, mental health, substance abuse, and socio-economic issues, including placement in foster care, homelessness, incarceration, physical abuse, and violence. Health disparities and rural isolation in West Virginia are significant contributors to rising risk, and Aetna places critical importance on confirming that at-risk children and youth with unmet physical and psychosocial needs are identified and receive needed care. Furthermore, there is a need to provide support and establish some sense of hope to children and adolescents who are attempting to cope with harsh environments. The known barriers and challenges encountered by these children now provide opportunity for the health care system to respond with innovative approaches that: 1) take advantage of the extensive network of community health centers and school-based health centers in our rural state; 2) link PCPs and BH providers with specialist psychiatric consultation, and; 3) provide more intensive and continuous care through the inclusion of community health

workers in the primary care team. Our collaboration with Cabin Creek Health Systems and Marshall Health Systems offers team-based intensive care management for at-risk youth in Elkview Middle School, Herbert Hoover High School, and Riverside High School in Kanawha County. The care team members include the following:

- Project coordinator
- Primary care provider
- Doctoral or master's level BH provider
- Community health worker/care coordinator
- Aetna care manager
- School representative
- Legal advocate
- Medical assistant
- Consulting psychiatrist

Referrals of high-risk youth come from Aetna as identified by its risk algorithm, as described earlier. Additional referrals may come from Cabin Creek, from the school, and from courts. The CCT is the hub for receiving input on the status of the youth and developing a coordinated plan that serves the holistic needs of the youth. It receives referrals, assesses the youth's level of risk, invites youth and their family members to be enrolled, and coordinates developing care plans. Team members may vary depending on the youth's needs, but the core group includes a medical provider, a mental health provider, a clinical care coordinator (medical assistant or nurse), a community health worker (CHW), a school representative, and parent or guardian. The role of the CHW is to work with the youth and their family in implementing the care plan. The CHW also helps families address social determinants that raise barriers to their wellbeing through identification of relevant community resources advocating for them when barriers to services arise. The program integrates BH and needed specialty care into school-based health centers and links at-risk youth to community-based resources to address social service and other personalized needs.

Programs for CHIP Members: We offer several opportunities for all WVCHIP members with specialized pediatric or adolescent needs. These programs are designed to help the member and family/circle of support engage proactively in their health care. Programs include the following:

- **Weight management:** Assists children and young adults (ages 10-18) with the reduction in childhood obesity through coordination with PCPs, education providers, nutritional specialists, or other community resources to promote healthy behaviors aimed at weight and health risk reduction. Members are encouraged to participate in Ted E. Bear, M.D.® events, community gatherings, and 4-H clubs. Aetna provides parents $50 towards participation in 4-H activities. We also offer nutritional counseling.
- **Texting programs:** Health-related text messages are delivered, including text4kids messages, which remind families of important health topics, such as education and milestone visit reminders.

Care Coordination for a Child with Complex Needs in the Eastern Region

Katy[12] is a six-year-old living in the eastern panhandle of the state who experienced seizures at birth and was recently diagnosed with cerebral palsy. She has difficulty walking and learning. Her mom homeschools her and needed help finding specialists, therapists, and durable medical equipment (DME) in her area. Katy's care coordinator offered face-to-face support for the family and connected Katy's mom to a local DME provider who arranged for Katy to receive a custom-to-fit jogging stroller, allowing Katy's mom to take her to the park. Katy's care coordinator also connected Katy's mom to an agency that helped her apply for a grant to cover special vision therapy that was not a covered benefit under MHT. She also referred Katy to West Virginia University Hospital for completion of neurodevelopmental testing. To address SDOH needs, the care coordinator pointed Katy's mom to a grant application for assistance in the purchase of new tires for the family's van and connected her to LogistiCare for additional transportation assistance. The care coordinator also helped the family apply for CSHCN eligibility. Katy's mom said she would not have known about these resources without the help of the care coordinator. Katy is now doing well in her services and at school and is able to have her ongoing needs met through supportive care management as a result of her progress and access to services.

- **Children's Health Administration of Medications Monitoring Program (CHAMMP):** CHAMMP involves a multidisciplinary team approach between Aetna and CVS Health to review the prescribing of psychotropic medications in children. Candidates under the age of 12 are identified through prescription claims data for multiple psychotropic medications, use of selective serotonin reuptake inhibitors, atypical antipsychotics, or mood stabilizers. We review data and outreach to the prescribing physician, the member, or family/circle of support to discuss prescribed medications, current services being received, and any identified needs. Our CM team

[12] Not her real name

then connects members to a BH specialist and provides continued follow-up as needed. We offer education around each medication and proper monitoring of labs if indicated.

- **Attention-deficit/hyperactivity disorder (ADHD) program:** Children with ADHD need timely, ongoing follow-up with their doctors. We send mailings to children receiving first fills of ADHD medication. Letters are sent at 3 and 5 months following first fills to remind members and their families/circles of support. We send a Tip Sheet to providers to encourage appointment scheduling. We assist with making the appointment and provide reminders to the PCP when follow-up is recommended. As a priority area, we have a quality improvement initiative to outreach calls to families of members with ADHD to ensure members receive timely follow-up care after an ADHD prescription.
- **Maternity care management for CHIP members:** Our CCTs will offer specialized prenatal care management for CHIP members; OB specialists are embedded in the offices of providers who deliver high-risk pregnancy services.
- **Autism spectrum disorders:** Aetna's board-certified child psychiatrist is available for consultation with Applied Behavior Analysis-credentialed providers throughout the state as well as for peer-to-peer consultations.

Programs for Adults: We offer a variety of care management interventions and programs for conditions and issues adults are more likely to face. These include the following (to name just a few):

- **National Diabetes Prevention Program:** Care coordinators refer pre-diabetic members or those with a diagnosis of obesity to our structured program, which includes providing education through weekly classes. Classes include education regarding healthy behaviors, goal setting activities, and weigh-ins.
- **Mammogram reminders and services:** Aetna conducts outreach calls and sends mailings to remind members of necessary mammogram screenings. Additionally, we collaborate with the West Virginia University Cancer Institute's Bonnie's Bus to offer mobile mammogram screenings.
- **Flu vaccination campaign:** We send text messages reminders about the importance of flu shots once per month from September through February to members who participate in our text4health Lifeline or cell phone text messaging programs. Care coordinators also inform vulnerable members (such as those who are pregnant or who have multiple chronic conditions) of the availability of the online educational material from Krames, which reinforces the importance of obtaining flu vaccinations.
- **Smoking cessation:** Aetna care management provides one-on-one coaching through our CCTs, which include a respiratory therapist and a care manager who has completed the Council for Tobacco Treatment Training Program to counsel members on smoking cessation and offer education regarding the negative effects of smoking/vaping. Additionally, we provide access to online educational and self-management tools to help members achieve their quit goals. Care managers assigned to pregnant members conduct assessments to determine if members are actively (or are at high risk for) smoking or vaping and target care plan goals to address any concerns.
- **Congestive heart failure program**: Aetna sends scales to members with congestive heart failure (CHF) and offers education regarding weight management; members complete weight

diaries for review with their provider and/or care coordinator. Care coordinators conduct condition-specific assessments and develop care plans with members that outline goals specific to CHF.

- **Compassionate care and end of life care management**: All CCT staff are trained on the stages of dying and incorporate this knowledge as they offer support to members facing terminal illness. Our oncology nurse on staff provides compassionate care interventions including educating members on advance directives and other end-of-life planning concerns
- **SUD specialists and peer support**: Aetna employs a SUD specialist care manager in every regional CCT as well as a peer support specialist with lived SUD experience who is available to offer support state-wide. These individuals have had SUD-specific training (such as ASAM) and possess experience that is critical in the engagement of members who are struggling with addiction. Additional information regarding SUD and OUD care management is provided throughout this response.

[CM013] Processes for Administering Care Management for Members with Complex or Serious Medical Conditions

Members with complex or serious medical conditions are enrolled in Tier 2 or Tier 3 care management and receive care management interventions based on those intensity levels, as previously described. Our chronic condition management program engages members with activities and services based on the identified needs of the member and structured to support the highest degree of member self-management. This program focuses on members with diabetes, congestive heart failure, coronary artery disease, depression, asthma, and COPD.

Risk-based activities and interventions include the following:

- **Low Risk:** Bi-annual-condition specific newsletter, health plan website, and links to resources; online resources including health appraisal and self-management tools.
- **Moderate Risk:** All interventions of the low-risk/population health program, in addition to care manager telephonic outreach to members to assess general and condition-specific needs; BH screening and support; condition-specific and preventive health education; information and resources, identification of person-centered goals, and development of an individualized care plan with measurable interventions; scheduled follow-up.
- **High Risk:** All interventions of the low-risk/population health and moderate-risk programs plus member outreach at least monthly; condition-specific in-depth education and care coordination provided by clinically licensed care managers; options for face-to-face visits in the member's residence or provider office.

Intensive Care Management for a Member with Serious Medical Conditions in the Central Region

Matthew[13] is a 51-year-old living in Kanawha County. He has chronic kidney disease, coronary artery disease, hypertension, peripheral artery disease, hyperlipidemia, arthritis, sleep apnea, cerebrovascular disease, seizures related to conduction disorder, and is dependent on insulin for diabetes management. He smokes cigarettes, and lives with migraines, depression, and anxiety. Matthew recently moved to Charleston from Cottageville due to his complex medical issues and the availability of more family support in Charleston. His care coordinator (who lives in the area and previously worked at CAMC Memorial Hospital for 20 years) has significant knowledge of the doctors and specialists in the region. Matthew needed a cardiothoracic doctor for recommended open-heart surgery and needed to find a new PCP since his move to the area. His care coordinator connected him to a cardiologist in Charleston as well as a new PCP that was close to his home. The PCP saw Matthew every two weeks for three months to work with him on diabetes management. When the care coordinator had first met with Matthew, his HbA1c was 14, and after working closely for several months with his PCP and care coordinator, his HbA1c was brought down to 6.9, and he had lost about 25 pounds in the process. The care coordinator also obtained transportation assistance for Matthew and went to every appointment with him, as Matthew was unsure he would understand all of the information the doctors shared with him. Matthew had open heart surgery and healed well. He continued with follow-up appointments and later saw a vascular surgeon at the CAMC Vascular Center of Excellence for surgery related to blood clots in his leg and foot. Matthew reports that he is feeling better and more confident that he can maintain his health. Since Matthew had open-heart surgery, vascular surgery, and got his diabetes under control, he has been able to get out and do the things that he loves to do, like mowing grass, working on his cars, and hunting. He verbalized to his care coordinator how much he appreciates the help feels his care coordinator truly saved his life.

[CM014] Processes for Administering Care Management for Children with Special Health Care Needs (CSHCN)

Most CSHCN receive Tier 3 intensive care management. We have provided a detailed description of typical Tier 3 interventions previously in this response. Aetna conducts collaborative activities with family-centered, community-based systems of coordinated care for CSHCN, including early intervention and screening, linkage with parent support groups and forums, and adolescent pregnancy prevention programs. We collaborate with the Office of Maternal, Child, and Family Health (OMCFH) to make and receive referrals between programs for members who may be eligible based on diagnostic eligibility criteria, improve members'

[13] Not his real name

sense of safety, enhance the member experience and access to services, coordinate care through the sharing of care plans, and reduce barriers to achieving health goals. Currently, we attend a monthly meeting with OMCFH to discuss strategies to remove or mitigate service barriers for individual children with special health care needs and to avoid duplication of services. We offer pediatric nurse care managers onsite at pediatric offices, and the nurses and office supervisor meet monthly to discuss and coordinate member care.

[CM031] Working with Members Who Do Not Want a Care Manager or Who Are Not Actively Engaged

Our screening tool does allow for members to opt out of care coordination if they choose. The option to opt out is also presented in the welcome letter that goes out to members. Through conversation and in our letters, we provide the contact number for Member Services and the local CCT for the members who have opted out should they later decide to engage in care management services. Members who have opted out of care management still receive educational newsletters twice per year and new member packets. Specialized mailings for pregnant women, wellness reminder mailings, and community outreach events are also available for members who have opted out of care management. As described earlier, training to support relationship development is provided to all new staff. Additionally, care management leadership monitors opt-out trends at the care coordinator level and deliver additional supervision and training as needed for care coordinators whose opt-out numbers are increasing.

We have previously described our protocols to make multiple attempts to engage members in the completion of their initial screening and our appointment reminder process to prevent members from missing a scheduled appointment, as well as the training provided to care coordinators to encourage the development of strong relationships with members. If a member

who is assigned to care management begins to demonstrate a pattern of disengagement from services (for example, misses multiple appointments or does not attend their ICT care plan review meetings), the care coordinator will conduct outreach calls to the member to discuss the importance of appointment attendance and offer solutions should the member report barriers to attendance.

Screening, Assessment, and Education

CM016	The Vendor should describe its process for performing screenings or assessments as part of its care management program, including, but not limited to, the following:
CM017	Members with special health care needs, defined as individuals with complex or serious medical conditions
CM018	Children with special health care needs (CSHCN)
CM019	Clinical, social, or other criteria used to determine which members require care management and assignment to care managers
CM020	Performance of health assessments
CM021	Implementation of targeted education programs
CM022	The Vendor should describe its process for creating educational materials and educating members and care management staff

Aetna's screening and assessment processes are designed to understand the holistic needs of members in order to identify the types of services and supports they need.

[CM016 – CM019] Initial Screening of New Members

[CM016] Upon receipt of a referral or enrollment notification, Aetna begins the initial screening process for all members. Aetna recognizes that West Virginia members may have, or may be at high risk for, a chronic physical, developmental, behavioral, social, neurological, or emotional condition requiring a broad range of evidence-based primary and specialized medical or BH and/or related services. These needs are screened in the initial contact with the member and their guardian/circle of support (if applicable) and on an annual basis (or as the member's life or health circumstances change). Aetna believes it is important to get members into the right care at the time they need it. We also understand that a lengthy screening process can be an

obstacle to a person who may be in crisis or has urgent needs. The most important goal for the initial contact with the member is to build trust and to stabilize the crisis if there is one. The initial screening process includes motivational interviewing techniques and is modified by assessing the needs of the member (in crisis situations, for example). All screening and assessments will fare better when relationships are forged based on values and a shared vision of a better life.

Health risk questionnaire: Upon notification of enrollment of any new member (via Department 834 files) or referral of a member for care management assignment, Aetna's automated outbound screening process is our first attempt to complete the HRQ with the member. The outbound system contacts the member (or the member's guardian, if applicable) to attempt to complete the HRQ, as has been described earlier in our response to **CM003**. We disclose to the member and their guardian how we will use the information gathered in screening tools. The HRQ is available in English and Spanish and can be completed via multiple avenues based on member and family needs. In addition to completing the HRQ through contact by the automated outbound system, HRQs may be completed in person, or via printed or web-based forms. **The HRQ screens several domains (inclusive of SDOH) and aims to identify members with complex or serious medical conditions and children with special health care needs [CM017, CM018].** The following areas **[CM019]** are reviewed in the initial HRQ screening:

- Confirmation and review of basic demographics
- Preferred language read/spoken
- General health and emotional health
- Condition-specific questions
- SDOH concerns (food, transportation, employment, housing and utilities, and interpersonal safety concerns)
- Utilization of services (PCP, Dental, BH, physical therapy, occupational therapy, etc.)
- Medications
- School attendance
- Smoking history
- Pregnancy status

The HRQ screening process allows for initial identification of those who may need care management. As described previously relative to criteria for care management tiers, members with low risk pregnancy or a chronic condition that requires some ongoing surveillance/support are immediately assigned to Tier 1 population health care coordination. If member responses to the HRQ screening meet clinical/SDOH criteria to trigger further evaluation, they are immediately warm transferred from the outbound call system to an Aetna CMA for additional assessment and referral to a dedicated, local care coordinator who will determine if they are assigned to Tier 2 (supportive) or Tier 3 (intensive) care coordination. All members providing positive responses to any screening question on the HRQ, and who may have multiple chronic conditions, SDOH barriers, or special health care needs receive this further screening **[CM017, CM018, CM019]**.

Outreach questionnaire (ORQ): When the member is warm transferred to the CMA, the CMA immediately completes a telephonic ORQ with members identified through initial screening for possible referral to Tier 2 or 3 care management. Aetna completes this additional screening to further identify care needs and engage members in care coordination. The CMA educates members on the tool and the establish a relationship with the member before asking questions that can be considered intrusive. They take account of the cultural needs of members and families when completing the tool. **[CM017, CM018]** The ORQ also identifies special, serious, or complex health care needs as it addresses the following: 1) immediate, current, and past health care, mental health, and SUD needs; 2) psychosocial, functional, and cognitive needs; 3) SDOH, including education and housing status; 4) ongoing conditions or needs that require treatment or care monitoring; 5) current care being received, including health care services or other care coordination; 6) current

medications, prescribed and taken; 7) support network, including caregivers and other social supports, and; 8) other areas as identified by Aetna or the Department.

Upon completion of the ORQ, the CMA warm-transfers the member to the care coordinator they have assigned (as described previously for **CM004**) who will continue further assessment, finalization of Tier 2 or 3 assignment, care planning, and general care coordination activities with the member, as described in the following sections.

[CM017, CM018, CM020] Additional Comprehensive Assessments

The assigned, dedicated care coordinator speaks with the member following completion of screenings for introductory purposes and to schedule an appointment for further assessment. If the member/family chose not to be warm-transferred to the assigned care coordinator following the initial screening and the assigned care coordinator has difficulty reaching the member, they will conduct the same outreach attempt process as described in our initial screening process. For a member who has experienced trauma, it is critical to find ways to minimize the need for them to recount painful events multiple times. Aetna understands members may become overwhelmed with providing responses to various screeners and assessments. In an effort to reduce any trauma associated with answering questions on these assessments/screeners, as well as to reduce redundancy and duplicative efforts, the member's care coordinator will reach out (with the authorization of the member) to agencies currently working with the member and their family, as well as previous providers, facilities, and sister agencies to obtain the results of their assessments, screens, and treatment history information. The results will be incorporated into the member's file, ensuring the care coordinator has access when needed. Additionally, and if authorized or requested by the member and their family/guardian, stakeholder agencies, providers, facilities, and sister agencies will be invited to join the ICT, to provide insight into

building a comprehensive member-driven integrated care plan, which will consider the unique needs of the member and their family/caregiver(s).

Aetna uses a range of assessments that are tailored to the West Virginia population. Due to their training in the field, care coordinators use their professional knowledge and information regarding the member's life and health experiences to decide which specialty assessments to conduct to ensure all potential special health care needs are addressed **[CM017, CM018]**. In addition, care coordinators use an algorithmic approach to choosing screening options. The system provides suggestions to care coordinators about detail to solicit during the in-person comprehensive assessment process. Care coordinators are educated on spending time efficiently with members, and by skillfully using motivational interviewing, they obtain the information necessary to complete special assessments without overburdening the member with multiple questions. Descriptions of many of these assessments follow here.

Health Care Equity Contact Event

The HCE, housed in our electronic care coordination system, is an assessment the assigned care coordinator conducts with members to determine if assignment into Tier 2 or Tier 3 care management is appropriate. The HCE documents, tracks, and reports on members' social determinants needs, and is inclusive of housing, transportation, food insecurity, personal safety, employment, education, and social cohesion, and identifies members who may benefit from additional interventions and education to address them. The demographic characteristics included in the HCE include age, race, ethnicity, gender, sexual orientation, and geographic location, among others. The intent is for the captured SDOH data to be incorporated into the development of the individualized person-centered care plan. When an SDOH need is identified, care coordinators can use technology, such as Aunt Bertha and Unite Us, to connect with community-based organizations

to identify resources to meet their needs. We also utilize this information to address root causes of members' challenges as well as to identify disparities and/or gaps in care. Details regarding our activities to address SDOH will follow later in this response.

Assessment of Trauma

Care coordinators use the Trauma Screening Questionnaire, when indicated, to conduct more thorough trauma assessments.

Assessment of Behavioral Health Needs

A comprehensive assessment of all potential special health care needs must include thorough evaluation of behavioral health. For members responding positively in the screening to questions related to emotional or BH needs, the care coordinator completes evidence-based assessments and screenings to evaluate BH concerns, which may include the following:

- Early and Periodic Screening, Diagnostic and Treatment Mental Health Assessment
- Child and Adolescent Needs and Strengths
- Child and Adolescent Service Intensity Instrument (CASII)
- University of California Los Angeles Child/Adolescent Post-traumatic Stress Disorder Reaction Index
- CRAFFT (adolescent SUD)
- UNCOPE (SUD)
- Patient Health Questionnaire-9 (for children 12 and older)
- Psychosocial Pediatric Symptom Checklist 17
- Generalized Anxiety Disorder 7
- Edinburgh Postnatal Depression
- Depression Assessment

Assessment of Chronic Conditions

Care coordinators use their clinical expertise and knowledge of the member's health to identify which condition-specific assessments to complete. The following is an example of some of the condition-specific assessments we use to identify special health care needs **[CM017]**:

- Diabetes assessment
- Hepatitis-C assessment
- HIV assessment
- Infant assessment
- Interval assessment
- Adult asthma assessment
- Pediatric asthma assessment
- Chronic obstructive pulmonary disease assessment
- Cancer assessment
- Heart failure assessment
- Hypertension assessment
- Sickle cell assessment
- Coronary artery disease assessment

- Perinatal assessment
- Weight management assessment

Condition-specific medication adherence is evaluated during interactions between the care coordinator and members diagnosed with targeted conditions such as diabetes or asthma. Condition-specific assessments are used to identify adherence issues and opportunities. Findings are discussed by the member's care team, and strategies to improve adherence are included in the care plan.

Upon enrollment in supportive or intensive care management, we send an Enhanced Care Plan notification letter to the PCP to inform them of the member's status with our care management program. With the member's authorization, we share all screening and assessment results the member's assigned PCP and permitted provider and stakeholder members of the ICT via letter or securely via email to providers upon request, as authorized by the member. This information is also available to the provider via the provider portal.

The care coordinator utilizes information gained through the assessment process to determine which care management tier (2 or 3) best meets the needs of the member (according to tier criteria previously mentioned) and assigns the member to the appropriate tier. The screening and assessment process lays the foundation for the creation of the member's initial care plan (to be described later in the response). Ongoing screening and assessment also continue throughout the member's enrollment. Screenings and assessments are repeated annually, at a minimum, or as triggered by a change in the member's functional or health status, or a change in their placement or residence.

[CM021, CM022] Targeted Education and Creation of Educational Materials for Members and Care Coordinators

Aetna offers member materials, education, and outreach in order to assist members with system navigation and the realization of their health care goals. **Equipping members with tools regarding the prevention or management of chronic medical or behavioral health conditions and how to access care is a key component to members' successful journey to improved health.** Educational materials support member self-sufficiency and reinforce other interventions identified through the care plan.

[CM021] Targeted Education Programs

Our targeted member education approach includes providing information to members and their families/guardians, which helps them better manage chronic conditions, offers them education and encouragement to learn self-management skills, and provides information to access the appropriate services and supports. Our efforts aim to educate and support members to prevent exacerbations of conditions and prevent hospitalizations and other high-cost health care resources. In this section, we provide descriptions of a few member educational materials and campaigns we already have available and plan to offer to new enrollees under this contract. Many are geared for adults or the guardians of child and youth enrollees; however, some specifically target younger children/youth.

Aetna's **Ted E. Bear, M.D.℠ Cub Club** provides children up to age 13 with health education regarding diet, exercise, and daily hygiene. Members receive notifications and challenges related to attending appointments and practicing healthy behaviors. Examples include challenges around brushing teeth, getting a healthy amount of sleep, and eating five servings of fruits and vegetables daily. Cub Club materials are specialized for children. Children receive rewards (such as blankets or a dental kit) for completion of challenges and activities and

graduate from the program at age 14. We also have an annual Ted E. Bear, M.D. Fair hosted in collaboration with CAMC. The event incorporates several educational interaction stations for children. Through our **National Diabetes Prevention Program,** we offer members with a diagnosis of obesity and/or prediabetes weekly, local one-hour classes over a period of 22 weeks with a specially trained lifestyle coach. During the classes, the member is weighed weekly and review their activity log from the previous week. They are provided education on making healthy lifestyle choices, educational handouts, and support to set goals and keep members motivated. Our **Family, Information, Support, and Help (FISH)** program provides education regarding common mental health issues that affect children and adolescents. The program offers support for the identified issues and coordinates resources to help. Additionally, Aetna sponsors **Baby Showers** in various regions across West Virginia. The events are marketed to the pregnant population in a given area/region and provide health and wellness information to help improve outcomes for women's pregnancies. During these events, we also provide door prizes such as Cribettes and information regarding our OB case management program. As previously described, we also offer extensive educational information to new parents through our "Healthy You, Healthy Baby" guide, as well as the "Safe Sleep" and "Keep it Cool" educational campaigns.

We have several **educational pamphlets** covering a variety of topics. These are written with an adult audience in mind, but some are relevant for the types of health issues that may impact children and youth. Educational pamphlet topics include the following:

- Getting Ready for Baby
- Staying Smoke-Free
- Depression After Having a Baby
- Your Baby's Development
- What to Do if Your Child Has a Cold
- Smart and Safe – Managing Opioid Medication
- Krames Family Planning Materials

We offer technology-based methods for providing additional health education. We inform adults and the guardians of children and youth of their option to receive text messages from us through information on the member handbook, our website, and contact with Member Services staff. If a member/guardian chooses to receive text messages, we can send them text messages, including a link to download our member mobile application. An interactive, mobile program sends personalized text messages free of charge to program members on the following topics:

- Care4life is a diabetes coaching program
- Text4kids provides reminders about well-child visits, exams for children timed to their age, and provides information as children grow
- Text4baby helps new mothers and expectant women to keep themselves and their babies healthy
- Text4health provides reminders for checkups and screenings and suggestions on what to do in between doctor appointments to help members stay healthy
- Text2quit is a program to help people quit smoking and stay smoke-free

In addition, we will employ a variety of mobile applications that are tailored to the needs of our members to cover topics like meditation and mindfulness, cognitive behavioral therapy, and acceptance commitment therapy methods to help people cope with depression, anxiety, anger, and stress. We will leverage the Breathe2Relax mobile app designed by the National Center for Telehealth & Technology to teach breathing techniques to manage stress. The skills taught may be applied to those with anxiety disorders, stress, and post-traumatic stress disorder.

[CM022] Creation of Educational Materials and Delivery of Education to Members and Care Coordination Staff

Member education materials are written with the understanding that our young members have legal guardians and extended family, or caregivers present in their lives. Our materials are geared toward educating both adult members and young members' guardians (where applicable). The materials are developed in collaboration with our community stakeholders, such as advocacy and disability groups. All materials, including member letters, are developed in

compliance with the guidelines in 42 CFR 438.104 and **Appendix D of the Model Service Provider Agreement, Marketing Policies.** This includes language with a reading level no higher than sixth grade, readable typeface, frequent headings, and short, simple explanations. We ensure that our electronic information is easily accessible and is presented in a format that can be retained or printed. Written material must be available in languages of the major population groups served, and in alternative formats such as braille. Members (and/or guardians) who require copies of assessments, care plans, or other documentation related to their care in a different language or format will receive these.

Any member materials targeted to children and youth include age-appropriate photos and language that is even more simplified than sixth-grade level, with heavier use of imagery and pictures as compared to materials for adults. Materials for older children, their families/guardians, and adult members contain more complex explanations and information.

We have already created a large library of printed and web- or electronic-based materials; therefore, we will be able to continue offering these materials for the new contract on day one. However, we are continually reviewing existing materials and adding new materials, and this will continue beyond implementation. Community Engagement staff and Care Coordination staff are trained as new education campaigns and materials are finalized, so they are immediately knowledgeable of new available educational resources. These staff members are responsible for delivering and reviewing member education materials in their respective interactions with the community and members. Care Coordination staff share educational material during their ongoing coordination of care contacts with members (e.g., during face-to-face visits, care planning meetings, etc.). Additionally, Community Engagement staff meet on a weekly basis to review member education materials and discuss

the best way to present the material. For example, training may include strategies for the presentation of material with an understanding of the culture in which the region will be presented. With many native West Virginians on our team, we are knowledgeable about these regional cultural differences and understand adapting our presentation style in the context of these differences helps to convey education material better.

Care Planning

CM032	The Vendor should describe its process for identifying members in need of treatment plans, and the development, updating and implementation of treatment plans wherein service coordination is required.
CM033	The Vendor should describe its process for the development of treatment plans, including, but not limited to, the following:
CM034	Including Primary Care Providers (PCPs) in the development of treatment plans
CM035	Sharing treatment plans with the member's PCP or other providers, as applicable
CM036	Staff responsible for sharing treatment plans with the member's PCP
CM037	Tracking of completion of treatment plans
CM038	Identification, tracking, and remediation of gaps in care
CM039	Processes for episodic and/or catastrophic care management interventions

West Virginians enrolled in Medicaid and CHIP may face vulnerabilities in their physical, social, and mental health, and Aetna provides quality care that promotes seamless access to services. Our local, regionally based CCTs understand the health disparities and risk to health equity for West Virginians, especially in the communities where they live and work. Care planning is member-centric and tailored to target these disparities. For purposes of this response, we call the treatment plan the 'care plan' and treatment planning 'care planning.'

[CM032 – CM034] Collaborative Care Plan Development, Implementation, and Updates

To provide seamless and accessible care management, collaboration is critical. Collaboration in care planning removes barriers and is vital to developing meaningful **integrated care plans which include health and life goals as identified by the member**. The care coordinator

creates an integrated care plan (ICP) with members enrolled in intensive (Tier 3) or supportive (Tier 2) care management **[CM032]** (while members in Tier 1 population health care coordination may create care plans with their PCP if they jointly identify the need for a plan).

Aetna's care management model utilizes evidence-based practices including TIC and the LifeCourse framework to create care plans in the member's voice with input from the member's chosen care team. The care coordinator facilitates care plan creation in collaboration with the member, their PCP **[CM034],** and the member's circle of support (e.g., identified family or friends), at a minimum. For members with the most complex needs, other people involved in the member's care may also participate on an ICT to contribute to the care planning process and ongoing care coordination efforts, as identified and permitted by the member. These additional team members may include physical health, dental, and BH specialty providers, the peer support specialist, CHWs, caseworkers assigned by other state agencies, school representatives, corrections representatives (if applicable), the Aetna clinical pharmacy advisor, and other SUD specialists. The ICT can also include extended family members and community members or other circle of support individuals, as identified by the member. The care coordinator serves as the single point of contact for the member. The ICT's goal is to operate with a 50/50 natural member-to-professional ratio to strengthen the impact of member and family voice and choice. The member ultimately determines the makeup of their ICT.

In alignment with national best practices and using the clinical models mentioned previously, such as LifeCourse, Aetna and our West Virginia CCTs are trained to understand and implement the core principles of member and family-centered thinking, planning, and most importantly, living. Key principles include the following:

- We acknowledge and recognize the valuable role each person in a member's circle of support plays within their social system
- We consider the impact of major life stages on members and their family and understand that their roles transform as they age
- We work together with members and their circle of support to create a clear vision of a positive quality of life and develop an attainable path toward those goals, understanding member's life stages are influenced by past experiences
- We move beyond planning for a member's health and safety by focusing on helping members and families increase their capacity to live a self-determined life in the community of their choice, while building social capital and economic stability
- We recognize that our members can and do lead complex, multifaceted lives and we account for this interconnectedness in our integrated service planning process by focusing on daily life and employment, community living, safety and security, healthy living, social and spirituality networks, and citizenship and advocacy
- We value the strengths and assets of our members and their families and support them to discover new opportunities and navigate their lives by sustaining and/or making new connections with the community, and by linking them to innovative goods and services available both internally and externally to the formal support system
- We provide opportunities and support for our members and their families to self-advocate and provide crucial feedback to Aetna through formal and informal stakeholder engagement channels. Aetna incorporates stakeholder experiences as a critical component of our continuous quality improvement process.

Figure 6.3.1-5 illustrates our member-centered approach to co-creating the integrated care plan with the member and their circle of support.

Development and implementation of the care plan [CM032, CM033, CM034]: The Aetna care coordinator develops the ICP in collaboration with the member (and their ICT where applicable) within 30 days of completion of the first screening for members in intensive care management, and within 90 days for members in supportive care management. All



Figure 6.3.1-5: Member-directed Care Planning
Aetna's care planning process seeks to understand the member's perspective to meet their unique needs.

participants in a member's ICT (including the PCP) may contribute to the development of the care plan. **[CM034]** The care coordinator sends a letter when the care plan is initiated to invite the PCP to participate in the process and contribute recommendations for the member's care plan. For those members with an established ICT, PCPs may attend ICT care planning meetings in person or by phone.

Members are empowered by the care coordinator to play a leading role in the development of goals and identification of needs as they relate to their ICP. The initial screening and comprehensive assessments completed by Aetna Care Management staff guide care plan development and help identify some of the member's needs. Goals, objectives, services, barriers, and interventions identified during care planning are included in the care plan. ICPs address all factors that impact the member's health to foster improved health outcomes. Aetna uses a numeric ranking to identify prioritization (i.e., goal #1 is the member's highest priority). Goals are specific, measurable, and timebound; timebound goals have a target completion date and intermittent time frames for reevaluation are specified. Care plans include documentation of near and long-term goals, incorporating the member's broader vision for their life. Interventions outlined in the care plan target the physical, behavioral, and social health needs of the member and make note of known barriers to care. Care plans may include special health care needs (such as obtaining durable medical equipment for a child with diabetes or arranging for SUD services for an adult who is abusing alcohol), specialty referrals, and strategies for development of skills to maintain independence and safety.

In addition to identification of needed health care services, ICPs also address members' social needs. Community services to address SDOH are included in the care plan, as are needed referrals and assessments for waiver qualifications. Care plans also include safety planning

interventions to pre-plan for natural disasters or crises. The care coordinator documents all ICP elements in our electronic care management system. **The most appropriate care plans are member-driven and provider-informed and ensure collaboration and continuity of care between physical health providers, BH providers, and others involved in the member's care to address the goals identified by the member and their circle of support.** The Aetna care coordinator serves as the facilitator of care plan development, implementation, and updates. The PCP and members of the ICT (where one is established) are valued contributors to ongoing assessment, care plan updating, and service delivery, but the care plan must be agreed upon by the member. As care coordination continues, the member, their circle of support, care coordinator, and the ICT (where applicable) meet according to the frequency described previously regarding care management tiers to review the care plan. They discuss the member's attendance with/access to services, barriers to access, member strengths, and the resulting progress (or lack of progress) towards their care plan goals.

Care plan updates [CM032]: Screenings inclusive of the HRQ are completed annually (at minimum) for all members assigned to any care management level of care. The ORQ and other specialized assessments are also completed annually (at minimum) for all members enrolled in Tier 2 or 3 care management. **Care plans are updated (at minimum) monthly for members in Tier 3 and quarterly for tier 2 care management.** Members in Tier 1 population health care coordination are assessed annually via the HRQ (with trimester screeners for pregnant members) and they collaborate with their PCP to update care plans where applicable.

Care coordinators set follow-up tasks in our electronic care management system to notify them when reassessment and care plan updates are due. The enhanced care plan module within our electronic care management system includes tracking of progress towards goals. This review

includes assessing whether the member's physical, behavioral, or social needs have changed. We run our predictive risk stratification analysis on all members on a monthly basis, as described earlier in our response, which may also alert us to changes suggesting an update to the care plan or possible assignment to different care management tier is needed. Outside of routine required assessment and care plan update intervals and monthly risk stratification, care coordinators may become aware of changes in a member's health or social needs status that would require an assessment and/or care plan update (e.g., a cancer diagnosis, loss of spouse, placement changes, inpatient admission, SDOH changes, or behavioral health crisis) through other means such as the following:

- Follow-up calls with members: every 30 days for intensive care management and every 90 days for supportive care management
- Interval assessments conducted telephonically or face-to-face with members
- Inpatient alerts or discharge planning processes

As explained previously in the description of care management tiers and the interventions associated with each, Aetna has also outlined minimum requirements regarding other types of ongoing care coordinator contact and intervention with members such as face-to-face contact. The goal of care coordination is to best meet the member's needs and aid in coordinating the services needed to reach their goals. One of the strengths of our local CCTs is the availability of face-to-face intervention and even home visits if needed when a member has experienced a significant life change or needs extra support. Care coordinators typically conduct face-to-face interventions via in person care plan update meetings, or during home visits to provide support, ad hoc assessment, or connection to additional services when a member's medications or life or health circumstances change significantly. Face-to-face visits help maintain and strengthen the rapport developed with the member and their circle of support.

At times of reassessment and update of ICPs, the member, care coordinator and their circle of support may identify that the member may be better served in a higher or lower level of care coordination intensity. If this is the case, the intensity and frequency of intervention is adjusted to the new tier-based requirements.

In 2019, Aetna conducted 1,796 face-to-face visits (an average of 156 per month) throughout West Virginia. With the rise in the number of face-to-face visits between Care Management staff and members, reports of increased rapport have been noted; member opt-out rates have decreased from June 2017 to present by 8%.

[CM035 –CM037] Tracking Completion of Care Plans and Sharing of Care Plans

[CM037] Care coordinators track timely completion of care management tasks through a search function in our electronic care management system that allows them to see when update tasks (such as an annual reassessment or required care plan update) are coming due or if any are overdue. Additionally, care management leadership conducts audits (monthly) and periodic review of tenure reports to ensure that screenings, assessments, care coordination tier identification, and integrated care plans are completed within all initial and ongoing/update required timeframes.

Copies of the current and prior assessments and care plans are stored in real time (as they are documented by the care coordinator) in our enhanced care plan module within our electronic care management system. Care coordinators mail enhanced care plan output letters (which includes detail of the care plan) to members, the PCP **[CM035, CM036]**, and permitted members of the ICT when requested, as authorized by the member. Care coordinators may also securely email assessments and care plans to providers upon request and if permitted by the member. Care plans are also available to permitted providers through the provider portal.

[CM038] Identification, Tracking, and Remediation of Gaps in Care

Aetna identifies gaps at the member and individual provider level through analysis of lists of a provider's assigned members and the preventive services delivered during a specific timeframe for members, and through routine review of the ICP and the member's access to/attendance with services. HEDIS and quality/gaps in care data are also reviewed to identify potential gaps related to many preventive health screenings and clinical care metrics, including annual dental visits, adult ambulatory or preventive care, immunizations, and colorectal cancer screenings, to name a few. When a care coordinator and ICT identify that a member's care is impacted by network gaps or a provider's inability to meet access to care standards or deliver preventive care, we mobilize resources to identify solutions for the member. The care coordinator may interact directly with the provider to identify and resolve barriers for the member's individual situation. Depending on the circumstances, the care coordinator may involve the network or Provider Relations teams to identify alternative provider options or may enlist the Utilization Management team to consider out-of-network single case agreements with providers who can meet the member's needs within timeliness expectations.

On a larger scale, Aetna conducts network gap analysis on an ongoing basis to quickly identify and respond to service gaps. We identify gaps through analysis of member density and geo-mapping data to determine the services that are unavailable in a particular region or across the state. We also utilize reports and monitoring tools to identify gaps such as the availability of network practitioners report, emergency room utilization report, network panel studies, and member and provider appeal and grievance data. When we identify a network gap, Provider Services staff develop a plan to resolve the gap with contract staff. There may be local providers who are well positioned to expand their array of services and need additional technical assistance from Aetna to

develop these new programs and service offerings. There may be out-of-network (and out-of-state) providers who have delivered services on a limited single-case agreement basis who would pursue a formal contracting relationship at locations within the state. For example, we executed contracts with Logan-Mingo (a BH/MAT provider in southern WV) and River Park Hospital (an inpatient/psychiatric residential treatment facility [PRTF]) provider in Cabell county) to close BH gaps after a period of utilizing their services through single case agreements. Provider Services staff will collaborate with Care Coordination staff, existing providers, community partners, and network counterparts at the Department to strategize and create the plan to develop the services in the regions where they are most needed.

Aetna establishes provider access to care standards in alignment with required time, distance, and appointment wait time standards as outlined in **Appendix K of the Model Service Provider Agreement**. All participating providers in our network are contractually obligated by provider agreements to adhere to timely access and appointment standards, including specific standards for specialty, urgent, and crisis services. Adherence to these standards are monitored through a variety of mechanisms including, but not limited to, the following:

- Geo-mapping analysis
- Evaluation of provider to member ratios, hours of operation, and appointment availability and after-hours coverage
- Provider surveys and site visits
- Member satisfaction surveys
- Review of closed primary provider panels
- Complaints

When we identify providers who are not meeting the access standards, Quality Management and Provider Services staff implement a series of steps (with progressively greater significance) to help providers achieve compliance. These efforts include the provision of technical assistance and analysis of barriers to achieving compliance and assistance in the creation and tracking of corrective action plans when necessary. Providers who continue to fail to meet the standards

may be referred to Aetna's Service Improvement Committee or Quality Management Oversight Committee, and ultimately may face network termination.

[CM039] Episodic and/or Catastrophic Care Coordination Interventions

Catastrophic care management is available to all enrolled members. This includes members with newly diagnosed cancer, trauma-related injury, or an acute behavioral event, to name a few. Aetna identifies catastrophic events through several avenues including utilization review activities (both prior authorization and concurrent review activities); inpatient alerts and ADT feeds; notifications by providers (physician or hospital); and notifications by community partners and parents and or guardians. **Once a catastrophic event is identified, the care coordinator immediately reaches out to the member.** If the member was not already enrolled in intensive care management (Tier 3), they are assigned to this level due to the catastrophic event and they receive a highly individualized range of interventions to help them manage the serious and complex conditions that are persistent and substantially disabling or life-threatening. Care coordination continues at this intensity until such time that reassessment and discussion with the member and their circle of

Care Management Support for Members Fighting Cancer

"Joann Good, registered nurse care manager from Aetna, collaborates with Edward's Comprehensive Cancer Center at Cabell Huntington Hospital weekly. She is embedded onsite every Tuesday, seeing Aetna members that are receiving treatment at the cancer center, including children seeing our pediatric hematologist/oncologist. She is a great resource for members diagnosed with cancer and trying to navigate their treatments when they are often feeling so overwhelmed. She assists with understanding their benefits, medications, education, transportation, gas mileage reimbursement, lodging, cell phone service, applying for disability, referrals, authorizations, community resources, nutritional supplement assistance, and any other social service resources per individual needs. She works with staff in the office to assist with coordination and care planning, approvals and denials, prior authorizations, and as a liaison to assist with any needs that may arise for the staff in dealing with patient needs. We look forward to an ongoing relationship with Joann and the team at Aetna."

—Molly Brumfield, RN, MBA, OCN
Manager of Medical and Surgical Programs
Edwards Comprehensive Cancer Center

support identify the situation has stabilized and the member's needs can be met at a lower intensity of care management. Our CCT can be highly specialized for our most complex members. For example, our high intensity specialized care team includes a **care manager who is certified in transplant management** and assists members in need of bone marrow and solid organ transplants.

During episodes of transition, such as discharge from a higher to lower level of care, Aetna employs transitional care management protocols. Transitioning from one setting to another can be unsettling and even frightening for vulnerable members and their family members. Aetna understands that effective transitions of care are paramount to maintaining and improving members' quality of care, quality of outcomes, and most importantly, quality of life. The member's assigned care coordinator promotes a seamless transition of care during discharges from inpatient facilities or placement changes with the aim of improving members' health and recovery, effectively coordinating their care, and reducing future admissions. Discharge planning begins upon admission through collaboration with the member, their circle of support, facility staff, and other members of the ICT.

Transitional care management activities are modeled after the Coleman Model, pioneered by Eric Coleman, MD, MPH, from the University of Colorado. Aetna uses the model's following four pillars to promote high-quality transitional care management:

- **Medication self-management:** We educate the member and family on medications and help them develop a medication management system
- **Use of a dynamic member-centered record:** Aetna documents all screenings, assessments and care plans in our electronic care management system and can share this information across providers and settings, where permissible
- **PCP and specialist follow-up:** Care coordinators support members to schedule and complete follow-up visits with PCPs or other outpatient specialists, and they educate members on how to be an active participant in their care

- **Knowledge of 'red flags':** We help members to identify when their situation is worsening and educate them on how to seek the appropriate level of care

Because members are at significant risk when moving from one setting to another, effective care transitions are vital to decreasing potentially preventable events. Our integrated care management model encompasses a strengths-based approach that empowers members to achieve their optimal level of functioning. Emphasizing continuity and coordination of care, Aetna collaborates with discharge planners at inpatient facilities to make sure each member receives the highest level of service and oversight to address their unique clinical and care management needs. Aetna understands that care occurs locally and has begun co-locating care managers at high-volume facilities such as CAMC, Thomas Memorial Hospital in the Central region, and West Virginia University Ruby Memorial in the Northern region. At this time, we have care management staff embedded in 10 hospitals and BH facilities throughout West Virginia. Having real-time resources locally available is key to eliminating barriers to care and supporting care coordination and providing the most immediate resources to our members.

We routinely monitor metrics (e.g., number of face-to-face visits, adverse incidents, number of members engaged in care management) to help make sure our assistance during transitional periods is impactful. CCT staff assist with transition through face-to-face visits with members, which provides valuable access to the treating physicians and other hospital staff so that that we manage discharge orders and referrals as seamlessly as possible for our member.

Our transitional care management approach relies on the availability of all medical records through connection to the WVHIN and our inpatient census. Aetna tracks ADT data and receives real-time notifications through the WVHIN. The care coordinator can retrieve the member's information, including primary care visits, SDOH-related needs, and medication and

pharmacy history to inform discharge planning. Aetna care coordinators review all elements of the provided data and coordinate discharge activities with Aetna UM staff, which conducts concurrent reviews as members' transition to new levels of care. The UM nurse coordinates with the care coordinator and other ICT members for all discharge needs so there is an efficient and safe discharge plan, meeting the needs of the member in the least restrictive setting, with all services ready for the member immediately upon discharge. We provide transitional care management for members to support transitions between institutional and community care settings, including transitions to/from inpatient hospitals, nursing facilities, psychiatric facilities, PRTFs, therapeutic group homes, residential SUD settings, and transitions out of incarceration.

Table 6.3.1-4 highlights key components of our program.

Table 6.3.1-4: Care Transition Approaches for Facilities across the Continuum of Care

Facility Type	Approach
Rehabilitation services, PRTFs, and therapeutic group homes	Care coordinators collaborate with providers and PRTFs prior to discharge to create a plan for outpatient services when the member returns to the community. Care coordinators have monthly or more frequent contact with the member and therapist and participate in care planning meetings. The care coordinator maintains contact with the member and their family following discharge to ensure attendance at follow up services.
Psychiatric hospitals	Aetna collaborates with West Virginia's psychiatric hospitals, which provide real-time discharge summary information to Aetna to allow for immediate transitional care management follow-up. Prior to discharge, Aetna care managers connect members to outpatient resources in their local community, including primary care, behavioral health, and non-medical resources.
Inpatient facilities	Transition from inpatient facilities is critical for members to succeed. Aetna's UM staff and care managers coordinate with discharge staff at the hospital to serve members where they are—close to their homes and circle of support. Aetna will continue to coordinate with hospitals to allow for timely implementation of transitional care management and outpatient services upon discharge.

Facility Type	Approach
Other transitions such as transitions out of incarceration	Aetna's Care Management staff work closely with members of the member's regional ICT to coordinate care and implement transitional care management activities. Care managers connect with incarcerated members before they are released to ensure referrals to services upon release. We have been contacted to start a program with Western Regional Jail to start transitions before release.

Pharmacy support: Care coordinators assisting members discharging from an inpatient facility or between levels of care review members' medication needs in their pre-discharge collaboration with the member and facility staff to verify that prescriptions have been sent to the member's pharmacy prior to the member's discharge and that the member (and/or their guardian if applicable) knows how and where to fill them. The care coordinator facilitates resolution of any barriers in this process with the member, the facility, or the pharmacy as needed. Additionally, medication reconciliation, defined as the process of comparing a patient's list of current medications to a physician's admission, transfer, and/or discharge orders, is known to be an effective strategy to reduce medication errors. In recognition that members discharged from the hospital are at increased risk for adverse drug events, Aetna medication reconciliation activities target those members discharged to home or other community-based residential setting. The process involves a call by the member's assigned care coordinator or by health plan staff if the member is not enrolled in care management, to the newly discharged member and/or caregiver. For those members called by a care coordinator, the care coordinator reviews the member's drug regimen, discusses the importance of medication adherence, helps the member identify barriers to adherence, and assesses the member's understanding of his/her medications. Other health plan staff conducting these calls screen for any medication changes and refer to a care coordinator if discussions are needed (review of medication regimens, the

importance of medication adherence, and assessing the member's understanding of his/her medications).

Social Determinants of Health

CM044	The Vendor should describe its approach to address Social Determinants of Health (SDOH)
CM045	The Vendor should describe its care coordination efforts that identify and address member access including, but not limited to, the following:
CM046	Employment
CM047	Food security
CM048	Housing Stability
CM049	Education
CM050	Social Cohesion
CM051	Resources that connect members to social supports and healthcare
CM052	Environmental needs
CM053	The Vendor should describe its plan to develop additional programs for Social Determinants of Health (SDOH)

Aetna recognizes the critical impact SDOH play in members' ability to access health care services. **In many cases, SDOH are the root cause barrier in members' ability to attend health care services**. If a member is unemployed, they may prioritize the need to secure a source of income first and attend to health issues later. A member living in a rural county without their own transportation is less likely to attend appointments without transportation assistance. A homeless mother of two will certainly be more concerned about obtaining shelter than making sure her children see the dentist. **Our role is to identify resources to remove SDOH-related barriers to health care** to not only resolve the SDOH concern, but to support members' ability to actively pursue and achieve all other health and life goals, free of the burden and stress of primary SDOH concerns. Aetna is aware that counties and regions have their own unique SDOH-related challenges, and that **the ZIP code or county where a**

member lives can have as much (or more impact) on a member's health outcomes as their family medical history and genetics. Aetna analyzes West Virginia data, which highlights regional SDOH challenges. For example, based on the 2018 Community Needs Assessment,[14] we know that residents of Boone, Putnam, Clay, Fayette, and Kanawha have identified a need for more employment opportunities and services. Through the 2018-2022 State Rural Health Plan,[15] we know that there are more than 40 counties in the state that are considered food deserts. Our regional CCTs, possess detailed knowledge of local challenges and needs, as well as the resources to address those needs, and offer swift assistance to help members in their communities remove or reduce SDOH-related barriers to care. Our SDOH approach is designed to address both regional and statewide needs.

[CM044, CM045] Approach to Addressing SDOH

Our approach to addressing SDOH in West Virginia is multi-faceted and includes the following:

- Local presence of Aetna care coordination staff that live and work in the communities where their assigned members reside and are keenly familiar with local resources, needs, and opportunities
- Assessment and identification of SDOH through HRQ screenings, the HCE, comprehensive assessments, and ongoing care planning with members and their ICTs
- Use of Aunt Bertha, West Virginia Family Resource Network, WV 2-1-1, Unite Us (in Clay, Kanawha, Boone, Putnam, Cabell, and Wayne counties), and internal SDOH Collaborative Resources guide to create SDOH service referrals and maintain a closed loop on service completion
- Mobilization of Care Coordination staff to connect members to SDOH services immediately when needs are identified, and additional partnership with CHWs at FQHCs where our care coordinators are onsite
- Daily integrated care management, UM, and BH rounds to discuss, identify, and find solutions to regional SDOH-related barriers
- Development of strong relationships with local SDOH service organizations
- Use of telehealth, as allowable, to promote access to care

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[14] EnAct Community Action, Community Needs Assessment May 2018, http://enactwv.org/wp-content/uploads/2018/05/EnAct-Community-Needs-Assessment-Report-Final-without-Appendix.pdf, accessed January 18, 2020
[15] West Virginia Department of Health and Human Resources, "Creating a Culture of Health in Rural West Virginia: State Rural Health Plan 2018-2022," (2018): accessed August 5, 2019;http://wvrha.org/wp-content/uploads/2017/08/2018-State-Rural-Health-Plan-Final.pdf, accessed January 18, 2020

- SOC model that is focused on care coordination and is community-facing—working with organizations, institutions, and facilities to reduce barriers and system gaps

During the initial screening process, members experiencing SDOH impacting their ability to access care (as identified on the HRQ) are warm transferred to a Care Management associate for further screening and assessment for intensive or supportive care management services. Members that are identified to have SDOH needs not requiring care management intervention are connected to tier one population health care coordination. Care coordinators are responsible to continually assess and identify SDOH concerns as they arise and to work with members (and their ICTs where applicable) to develop and update care plans

Aetna Care Coordinator and Williamson Health and Wellness CHW Work together for a Member with Complex Issues

Robert[16] lives in Williamson. He was diagnosed with cancer, was recently divorced, lived alone, and was providing care for his mother. He was feeling anxious about his cancer diagnosis and was worried about whether he could continue to take care of his mother and even if he could take care of himself. He was referred to Aetna care management during inpatient hospital discharge planning. At the time, he had been traveling almost two hours each way to and from Huntington to receive chemotherapy and reported the car rides were extremely uncomfortable for him. The Aetna care coordinator connected Robert to a registered nurse and CHW at the Williamson Health and Wellness Center. The CHW meets with Robert in his home one or two times a week. The care coordinator also helped reduce SDOH-related issues related to his long travels for chemotherapy by connecting him with a home care agency in Logan. The agency was able to provide a travel cushion at reduced cost and staff from Williamson using CHW funds to purchase the cushion for Robert. Additionally, the care coordinator contacted a local church in Belo that agreed to deliver hot meals to both Robert and his mother. Robert uses his cushion on his trips to Huntington. He tells his care coordinator that it is a relief on his hips during the duration of the car ride. Robert stated that he feels like Aetna is so much more than "just an insurance company" and is very thankful for the support and resources. Robert has been able to avoid further emergency room visits and inpatient stays and is planning to find a church group after he completes his chemotherapy so he can increase his social interaction.

[16] Not his real name

that identify resources to address the SDOH concern. Care coordinators ensure connection to these resources and track the issue to ensure the member obtained the needed service.

[CM046 – CM049, CM050 – CM052] Care Coordination Efforts to Address Access Issues Related to SDOH

As a result of our longstanding presence in West Virginia, Aetna has identified meaningful resources to address SDOH through the development of collaborative working relationships with community organizations that provide critical supportive services and programs.

[CM046] Employment

When we identify that a member needs assistance related to employment via completion of the HRQ, HCE, and other assessment tools or during the care planning process, we access the following resources (to name a few), based on the member's unique needs:

- **Workforce West Virginia:** We refer members seeking assistance in obtaining employment to Workforce West Virginia. Care coordinators are trained to understand and share information regarding their services with their assigned members. Additionally, we send mailers to all membership regarding Workforce West Virginia services and include their phone number on our website. Our outbound interactive voice menu also offers information regarding this important resource.
- **Job Corps:** We collaborate with Job Corps to link low-income members aged 16 to 24 (24 and older for those with disabilities) in Charleston and Harper's Ferry to Job Corps programs. Members who become Job Corps students can receive training and education to develop skills in a broad spectrum of employment roles ranging from carpenter to office manager, computer technician, medical and dental assistants, and heating, ventilation, and air conditioning specialists, to name a few. Job Corps also facilitates recruitment of students into employment opportunities.
- **Temporary employment:** Care coordinators help members connect with temporary job placement agencies such as Manpower to introduce them to employment opportunities.
- **CVS Workforce Initiatives:** CVS Workforce Initiatives provides Aetna with access to existing CVS partnerships that can help Aetna West Virginia members obtain the skills needed to build career-focused employment. CVS Health Workforce Initiatives offer hands-on training programs for

Occasionally, there are events that require special assistance. In February 2018, there was a prolonged teacher's strike, and because schools were closed, school meal programs were sharply reduced and, in many locations, they were completely halted. Aetna responded immediately by giving $3,000 to Facing Hunger Food Bank and $10,000 to Mountaineer Food Bank to help make sure students facing food insecurity would be provided for during the closures.

individuals looking for employment as pharmacy technicians and retail associates. Our CVS Health National Apprenticeship in partnership with West Virginia Workforce Boards includes classroom and on-the-job training with four U.S. Department of Labor-registered apprenticeships for pharmacy. The Charleston West Virginia Job Corps provides tuition-free pharmacy technician training at the Job Corps center for youth ages 16 to 24. CVS Health Workforce Initiatives also partners with West Virginia Junior College by providing pharmacy technician externships at local CVS pharmacies. Since 2015, CVS Health has hired 1,739 new West Virginia employees through its workforce initiatives.

[CM047] Food Security

Proper nutrition is a cornerstone of optimal health. Aetna recognizes the relationship between health care disparity and food insecurity. This is especially pronounced in West Virginia, which has some of the highest rates of poverty and food insecurity across the nation. The devastating effects of poor nutrition on brain development and growth render West Virginia children at a major disadvantage early in life. This can also set them on a path of poor health and socioeconomic standing as an adult. Care coordinators identify members with food security needs through screenings, assessments, and the care planning process as previously described. They then utilize Unite Us (who provides referral status feedback) and/or the following resources to coordinate care for members with needs related to food insecurity:

- **Connection to food banks and food pantries:** Care coordinators are familiar with the food banks and food pantries available to members in their neighborhoods and connect them to these resources as needed. Aetna has a longstanding relationship with West Virginia's two food banks, Facing Hunger and Mountaineer Food Banks. In addition to supplying the funding and volunteers that make the distribution of healthy food possible, we provide health care information and personal care items.
- **WIC and SNAP:** All newly identified pregnant members receive a welcome packet with information on how to enroll in the WIC program that provides subsidies for the member to receive food products. We provide information regarding how to apply for SNAP to all members.
- **Mobile Food Pantries: Aetna is the only managed care organization in the state to offer mobile food pantries.** We offer events throughout the state **(including Boone and Kanawha counties where food insecurity is a pronounced concern)** where we distribute food we have purchased from Mountaineer Food Bank and Facing Hunger Food Bank. Typically, we distribute perishable goods (that are otherwise unable to be stored long-term at fixed food bank locations) to residents in their local communities. Our mobile food pantries are run by Aetna staff at least every two months. Since 2018, Aetna sponsored the distribution of about 66,000 pounds of food, which equates to **55,000 meals.**

- **Hunger Hotline:** Care coordinators connect members to services available through the United States Department of Agriculture's Hunger Hotline which, among other services, offers information regarding access to meals for school-aged children during the summer (when they are unable to receive meals from school).

Aetna Stands Out as Supporter of Hunger Free West Virginia

Hunger Free WV is a collaboration lead by the state's two food banks: Facing Hunger Food Bank and Mountaineer Food Bank. In addition, the group brings together a variety of members including The West Virginia Department of Education, West Virginia Department of Agriculture, and USDA as well as local food pantries and feeding programs. Hunger Free WV interacts with policy makers to improve situations that effect hunger and food insecurity. This culminated with a full day of recognition at the West Virginia Legislature in January 2020. There was also a proclamation by Governor Jim Justice recognizing the day. Aetna is proud to be the sole MCO involved with Hunger Free WV as a supporter since the program's inception in 2018. We have provided financial support to this endeavor and we had an information table at the event at the Legislature in January. We are available to assist with policy discussions from a health and Medicaid standpoint.

[CM048] Housing Stability

Availability of safe housing is a core human need. Without it, members can think of little else and are much less likely to attend health care services or engage in a healthy lifestyle. The HRQ, HCE, and other screening and assessment tools, as well as ongoing care activities, help care coordinators identify when a member has an urgent housing need. At times, the care coordinator may also be made aware of the need for a particular member by the UM or Member Services department. If the care coordinator is aware of a member's imminent housing need, the care plan is updated and the care coordinator mobilizes to find housing options, both short- and long-term. Care coordinators have the knowledge and skill to connect members experiencing housing instability to local and county-specific resources including homeless shelters, Housing and Urban Development and Section 8 application processes, and sober/transitional living options. For example, we connect members in Cabell county to Harmony House and utilize the Affordable Housing website, which allows us to search housing options by ZIP code and to request registration on housing wait lists. Additionally, Aetna care

coordinators frequently connect members to the West Virginia Coalition to End Homelessness, which offers assistance to people seeking housing.

Assistance for a Homeless Member in the Northern Region

Antonio[17] was living in his car when he met his Aetna care manager. Antonio faces several health challenges including type 2 diabetes, neuropathy, hypertension, high cholesterol, and a history of prostate cancer. He also had recently been inpatient with a brain bleed and was only able to work ten hours per week at his job, so he was under financial strain. Antonio was enrolled in Aetna's intensive care management and his care manager developed a care plan with Antonio helped him apply to Unity Housing. When Antonio was approved to move into his own apartment complex, he called his care manager and was overwhelmed with gratefulness. His application with SSI is pending. His blood sugars are now staying within normal limits, and his neurologist has released him for six months.

[CM049] Education

Education opens members up to a world of possibilities. Lack of education, on the other hand, is tied to illiteracy (in terms of academics, life skills, and health) and fewer opportunities for stable and meaningful employment and income. Using the assessment and care planning activities previously described, Aetna care coordinators identify members with goals related to education and include these goals in the care planning process. In addition to programs like Job Corps (mentioned earlier), care coordinators connect members to information regarding how to sign up for GED classes. They can also inform members about the tuition assistance programs available within the West Virginia community and technical college systems. We additionally refer members to Jobs and Hope at WV.gov, which offers a wealth of information and resources regarding education, internships, and transportation.

[17] Not his real name

[CM050] Social Cohesion

Connection to family, friends, and community is key for members in their quest for optimal health. Not only does connection foster general wellbeing and happiness, members who are connected to a circle of support have a broader safety net of people they can count on to be advocates and offer help in their attainment of health goals. Care coordinators assess members' circles of support and help identify resources to augment this support system. Care coordinators may link members to faith communities (based on member interest/preference) or condition-specific support groups such as West Virginia Cancer Crusaders, Autism Speaks West Virginia, American Cancer Society, diabetes support groups, Mountaineer Spina Bifida Camp, and social and recreational groups such as Third Base, Boy Scouts/Girl Scouts, Big Brothers/Big Sisters or 4-H, to name a few. Aetna is also proud to sponsor Camp Appalachia. This year-long camp is available to youth ages 7 to 17 who are at risk due to having special health care needs, exposure to the opioid epidemic, or who have parents who are incarcerated. The camp offers a summer residence program as well as day camps with a focus on opioid use prevention, outdoor education, resilience, and leadership skills. Aetna has provided both financial support and volunteer support from Aetna staff. Additionally, Aetna sponsors other camps for members with asthma and juvenile diabetes.

[CM051] Connecting Members to Social Supports and Healthcare

Care coordinators have primary responsibility for connecting members to organizations and services which mitigate SDOH-related barriers. As needs are identified during screening and assessment, they are included in care plan goals for follow-up by the care coordinator to ensure the resource identified to address the SDOH barrier has been contacted. Care Coordination staff receive training on a variety of tools that they use to refer and link members to the help they need:

- **West Virginia-211:** Website for SDOH resources that allows for ZIP code and county level search of SDOH-related resources
- **Aunt Bertha:** Nationally used comprehensive online directory that includes local SDOH resource information
- **Unite Us:** Aetna is currently implementing the use of Unite Us, a closed loop SDOH service referral platform in in Clay, Kanawha, Boone, Putnam, Cabell, and Wayne counties
- **WV Family Resource Networks**: Offers lists (by county) of community resources and contact persons
- **Internal resource lists:** Aetna maintains additional internal resource lists such as our SDOH collaborative worksheet to supplement any areas/services not described in the tools previously mentioned

Care coordination staff are also familiar with processes to assist members attain transportation assistance, as well as the telehealth options that may be available to them, which offer ease of access to care. At this time, telehealth is an underutilized tool that could be used to mitigate limited access to services in rural areas of the state and transportation issues with having to travel to one of the three major medical centers. **Currently, our local BH medical director and clinical liaison are participating on the State's telehealth policy panel.** We look forward to finding creative solutions to improve access to care, not just for our members but all residents of the state of West Virginia. While telehealth options are limited to particular services, provider types, and settings in West Virginia at present, we are committed to the advancement of telehealth in the state as demonstrated by our collaboration with West Virginia University (WVU) through the WVU PALS program. It is a telepsychiatry program that enables PCPs to consult with a psychiatrist about the care and management of children and adolescents. We gave WVU a $50,000 grant to assist with start-up. This program is promising because WV has a shortage of psychiatrists and oftentimes the PCP is the one who is managing psychotropic medication, educating parents/guardians, and working with therapists and other outpatient providers. We also collaborate with Anytime Pediatrics and Nationwide to provide telehealth for pediatric oncology patients.

[CM052] Environmental Needs

In times of environmental disruption or disaster, Aetna care coordinators quickly step in to assist members. This may include connecting members to churches who help with home modifications for members with disabilities or domestic violence shelters for members who need safe haven. Other examples of resources we connect members with for assistance with environmental needs include the following:

> During flooding emergencies in June 2019 in western, central, and southern West Virginia, Aetna care coordinators contacted impacted members to make sure their needs were being met. Care coordinators helped enrollees with referrals to FEMA, Red Cross, Salvation Army, Catholic Charities, and Appalachia Service Project for housing and home repairs. We also provided information regarding multiple community clothing and food drives communicated to members.

- **EnAct Community Action:** Utilities assistance
- **Federal Emergency Management Agency (FEMA)/Red Cross:** Disaster recovery
- **NEHP, Faith in Action, and Heart in Hands:** Emergency repairs of gas lines, furnaces, etc.
- **Big Creek People in Action:** An organization providing numerous supports related to home modifications for persons with disabilities and making poor housing conditions more livable; they also offer help regarding education, literacy, and GED attainment

[CM053] Plan for Development of Additional SDOH Programs

As described previously, we currently utilize Aunt Bertha, Unite Us, WV-211, and other internal resources to identify and connect members to services and organizations that address SDOH. We remain committed to easing access to these services on a statewide level and look forward to partnering with the Department as they evaluate state-wide solutions. In the interim, we will continue to evaluate our current processes and resources for enhancement. At present, we are currently looking to expand SDOH referrals to a newly identified option called The Maker's Center. The Maker's Center is offered in the central region by Bible Center Church at multiple locations. The Maker's Center offers volunteers and mentors who teach attendees skills related to construction, technology, sewing, floral design and woodworking to broaden members' marketable skills for employment opportunities.

Special Care Coordination Circumstances

CM040	The Vendor should describe its protocols for addressing a provider that does not perform coordination activities that includes, but is not limited to, the following:
CM041	Identification
CM042	Actions taken to improve coordination
CM043	The Vendor should describe its programs for coordination of care with community resources and social services for its members.
CM061	The Vendor should describe its process to refer all eligible pregnant members to the Bureau for Public Health's (BPH's) Women, Infants, and Children Program (WIC) for nutrition and services during and after pregnancy.
CM062	The Vendor should describe its process to coordinate with the Bureau for Public Health's (BPH's) Office of Maternal, Child, and Family Health (OMCFH), Office of Nutrition Services (ONS), and Office of Community health Systems and health Promotion (OCHSHP) to link members with necessary public health prevention and support services.
CM063	The Vendor should describe its protocols to coordinate care for members receiving Social Necessary Services (SNS) through the Specialized Foster Care Administrative Services Organization (ASO).
CM064	The Vendor should describe its process to share information for children enrolled in the Specialized Foster Care Managed Care Organization (MCO) including, but not limited to, authorization data, medical history, claims history, medical records, and other patient information.

Aetna's extensive experience working with enrollees across a broad spectrum of eligibility categories ensures that we offer seamless coordination and continuity of care with other stakeholders involved in member care.

[CM040, CM041, CM042] Improving Provider Participation in Coordination Activities

As ongoing care coordination continues, if the care coordinator or UM team member identifies a provider that is not contributing to collaborative activities as expected (such as not providing input to the care plan or at ICT meetings, following up on communications between team members, or participating in prior auth/concurrent review activities), they may outreach the provider liaison assigned to the provider for assistance in getting the provider to respond or step

in. If the provider does not respond to provider liaison involvement, additional steps (such as issuing a quality of care concern, if applicable) may be taken.

[CM043] Coordination with Community Resources and Social Services

Throughout the care planning process and ongoing care coordination efforts for all members, the care coordinator and ICT identify community resources and social services that may address the needs or goals outlined in the member's treatment plan. These needs are re-evaluated at the reassessment and care plan update intervals (or when there is a significant life or health change) as described previously. When a particular community resource or social service is identified as a need, the ICT establishes in the care plan the date by which the service must be procured, depending on the urgency for the individual member. Representatives of organizations offering community resources or social services may be invited for ICT meetings as needed, with permission of the member.

We have well-established relationships with West Virginia community resources and social service agencies such as the following: Right From the Start, Birth to Three, the Children with Special Healthcare Needs program, CPS, DXC Technologies Inc. (formerly Molina), Perinatal Partnership, Adverse Childhood Experiences (ACES) Coalition, American Cancer Society, Youth Advocate Program, Our Babies: Safe and Sound, Help Me Grow West Virginia, Helping Appalachian Children and Infants, Tobacco Free Families Advisory Council, March of Dimes, Mountain State Healthy Family, Circle of Parents, PROACT, WIC, and Mountains of Hope.

[CM061, CM062] Referrals to and Collaboration with WIC/Office of Nutritional Services

We deliver mailings regarding WIC program highlights and access/application processes to all membership, including pregnant members. Additionally, pregnant members and new parents receive our "Healthy You, Healthy Baby: A Guide for Moms and Families," which offers

additional information regarding WIC resources and applications. When a care coordinator identifies a member who may be eligible for WIC, they assist the referral via sending referral packets to the program. Additionally, WIC leadership have delivered trainings to staff regarding the program and we will continue to invite them to provide additional trainings in the future. We also meet with WIC leadership to collaborate around shared goals. Unite Us offers connectivity with WIC referrals as well. Our care managers refer to reduced lunch programs and refer to WIC famer's markets and grocery stores. We connect members to FQHCs that give vouchers for use in the Farmer's Market nutrition program as well.

[CM062] Referrals to and Coordination of Care with Office of Maternal, Child and Family Health (OMCFH) and Office of Community Health Systems and Health Promotion (OCHSHP)

Aetna will focus on collaborative activities with family-centered, community-based systems of coordinated care for children with special health care needs, including early intervention and screening, linkage with parent support groups and forums, and adolescent pregnancy prevention programs. Our staff work with the OMCFH to improve members' sense of safety and the member experience and access to services, with the aim of reducing barriers to achieving health goals. Currently, we attend a monthly meeting with OMCFH to discuss strategies to remove or mitigate service barriers for individual children with special health care needs. As described previously, we offer specialized care management for babies with NAS and follow them closely for their first year of life. As another example, CCTs work with schools and school districts to ensure children transitioning (from birth to age three population) to the school system have Individualized Education Programs where appropriate. We work with the OMCFH to track success and address any barriers. We collaborate with public health leadership on their

diabetes program, which offers members condition-specific education. Additionally, we attend quarterly meetings with OCHSHP leadership to collaborate around shared goals.

[CM063] Coordination of Care for Members Receiving Socially Necessary Services (SNS) Through the Specialized Foster Care Administrative Services Organization

As the recipient of the award for the Mountain Health Promise program serving children in foster care and other special eligibility categories, there is a built-in ease of coordination of SNS services between our Medicaid line of business and our Mountain Health Promise plan with KEPRO. While we comply with professional and legal boundaries between the two programs, we are confident that our standardized processes, common care management practices, and access to population health information promote exceptional cross-coordination. We will collaborate to formalize a process for KEPRO to notify our MHT/WVHB/CHIP Care Management team when our members have been referred to SNS services by CPS or a youth service worker. This notification will allow for ongoing care coordination between our plan, KEPRO, and the member and their circle of support. We will also expect that KEPRO offer these notifications to other MCOs as needed to coordinate care.

[CM064] Information Sharing for Children Enrolled in Specialized Foster Care MCO

Given our status as the managed care organization for both the Mountain Health Promise population and MHT, and WVHB services, we are confident that all Aetna staff working within these two programs are trained and competent in following our transition of care policy, which outlines requirements for the sharing of information to coordinate care. With the member's permission, information about previous service and provider history, authorizations, claims, and medical records, as well as assessments and care plans, can be shared across programs to prevent disruption of service. Per policy expectations, we will facilitate the sharing of requested information (as permissible by law and member authorization disclosures) to assure seamless transitions

between the programs and continuity of care for the member (and families) involved. Our longstanding relationships with stakeholder representatives, from CPS and other child welfare agencies, further strengthen our ability to provide prompt response to requests for information and to offer a safety net for members as they transition to foster care program enrollment status.

Addressing Prescription Drug Abuse

CM015	The Vendor should describe strategies to manage members with a history of prescription drug abuse, and processes for monitoring potential abuse or inappropriate utilization of controlled prescription medications.

Prescription drug abuse and related opioid addiction is a crisis across the country. **Aetna is committed to reversing the rising trend of polypharmacy, prescription drug abuse, and related opioid abuse**. We execute strategic solutions that focus on the needs of our members and ensure initiatives and programs integrate pharmacy, behavioral health, and physical health. Our programs and collaborations, such as our **NAS care management program** and our relationship with Provider Response Organization for Addiction Care and Treatment (PROACT), connect members to providers and give members seamless access to the right support—encompassing mind and body—to fight addiction. Everyone has a role to play if we have any hope of slowing this epidemic; this includes members, families, medical professionals, insurers, addiction counselors, and the public at large. We are applying data analytics, clinical insights, and collaborations along the continuum of addiction and recovery to implement data-driven initiatives and improved outcomes. We are working to prevent misuse and abuse, intervene when we identify at-risk prescribing or utilization behavior, and support those who are addicted through evidence-based treatments. We have SUD care management specialists and a peer support specialist with lived experience with SUD who offers members insight and guidance in obtaining needed services.

The severity of these issues in West Virginia is evidenced by high age-adjusted rates of drug overdose deaths involving opioids, increase in opioid-involved overdose deaths for synthetic opioids other than methadone, high opioid prescription to resident ratios, and increase in the rate of NAS/neonatal opioid withdrawal syndrome (NOWS) cases[18]. In many cases, these negative indicators in West Virginia represent some of the highest in the country.

Overdose may result from the use of illicit drugs but can also result from the misuse of prescription medications and over-the-counter medications. Polypharmacy-related deaths are increasing. In West Virginia, the average number of drugs involved in fatal overdoses has increased, from 2.3 drugs per fatal overdose in 2001 to 3.5 drugs per fatal overdose in 2015 (West Virginia Health Statistics Center, 2017).[19] Among the 830 West Virginians included in the 2016 West Virginia Overdose Fatality Analysis who died from overdose in 2016, 86 percent had multiple drugs in their system at the time of death.[20]

Aetna's five-year goals to combat this crisis are the most ambitious in the industry and include the following:

- Increase members with chronic pain who are treated by non-opioid treatment alternatives by 50 percent through an evidence-based multimodal approach (such as physical/occupational therapy, chiropractic care, acupuncture, psychotherapy, biofeedback, and local therapeutic injections)
- Reduce inappropriate opioid prescribing for our members by 50 percent (focus on members with known past opioid overdose, concomitant benzodiazepines and opioids, members receiving opioids with existing OUD diagnosis, and opioid prescriptions greater than one-week duration for acute condition

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[18] National Institute on Drug Abuse West Virginia Opioid Summary: accessed January 23, 2020; https://www.drugabuse.gov/opioid-summaries-by-state/west-virginia-opioid-summary
[19] West Virginia Department of Health and Human Resources Bureau for Public Health, "West Virginia Drug Overdose Deaths Historical Overview 2001-2015": accessed January 19, 2020; https://dhhr.wv.gov/oeps/disease/ob/documents/opioid/wv-drug-overdoses-2001_2015.pdf
[20] 2016 West Virginia Overdose Fatality Analysis: accessed January 23, 2020; https://dhhr.wv.gov/bph/Documents/ODCP%20Reports%202017/2016%20West%20Virginia%20Overdose%20Fatality%20Analysis_004302018.pdf

- Increase members with OUD who are treated with medication assisted treatment (MAT) and other evidence-based treatments by 50 percent

The Aetna Medicaid Opioid Taskforce recently introduced our **opioid dashboard** that provides national and state-specific data regarding progress toward our project goals. The dashboard uses pharmacy and medical claims data to trend key metrics to help us combat inappropriate use of opioids. The dashboard allows for heatmapping of opioid use down to the county level, enabling targeted intervention efforts aimed at improving member health outcomes. As an example, we have engaged with providers to promote the adoption of MAT programs and have identified a Care Management Program Opioid Champion, whose role will be described in greater detail later in the response. Data from our opioid dashboard demonstrate our success across all Medicaid plans. For example, between July 2016 and December 2019, the Aetna Medicaid organization increased the rate of non-opioid treatment for chronic pain by 34.9 percent and decreased the rate of opioid prescriptions for members with OUD by 55.8 percent. **Figure 6.3.1-6** demonstrates some of the West Virginia outcomes monitored on the dashboard.

Fueled by cross-functional collaborations and insights, the Aetna enterprise's opioid initiatives have yielded meaningful results. In the first year since announcing our five-year enterprise goals, we have seen a 34% increase nationally in the rate of medication-assisted treatment or other evidence-based treatments used by members with OUD, among other accomplishments.

Aetna's comprehensive strategy to combat the prescription drug abuse epidemic includes the following:

- **Prevention:** Identification of alternatives to opioid prescribing and educating the public and providers about the dangers of prescription abuse or misuse
- **Intervention:** Identification of at-risk prescription utilization or abnormal prescribing patterns and intervention to address problems as they are found
- **Support:** Utilization and promotion of evidence-based practices to help members overcome prescription drug abuse

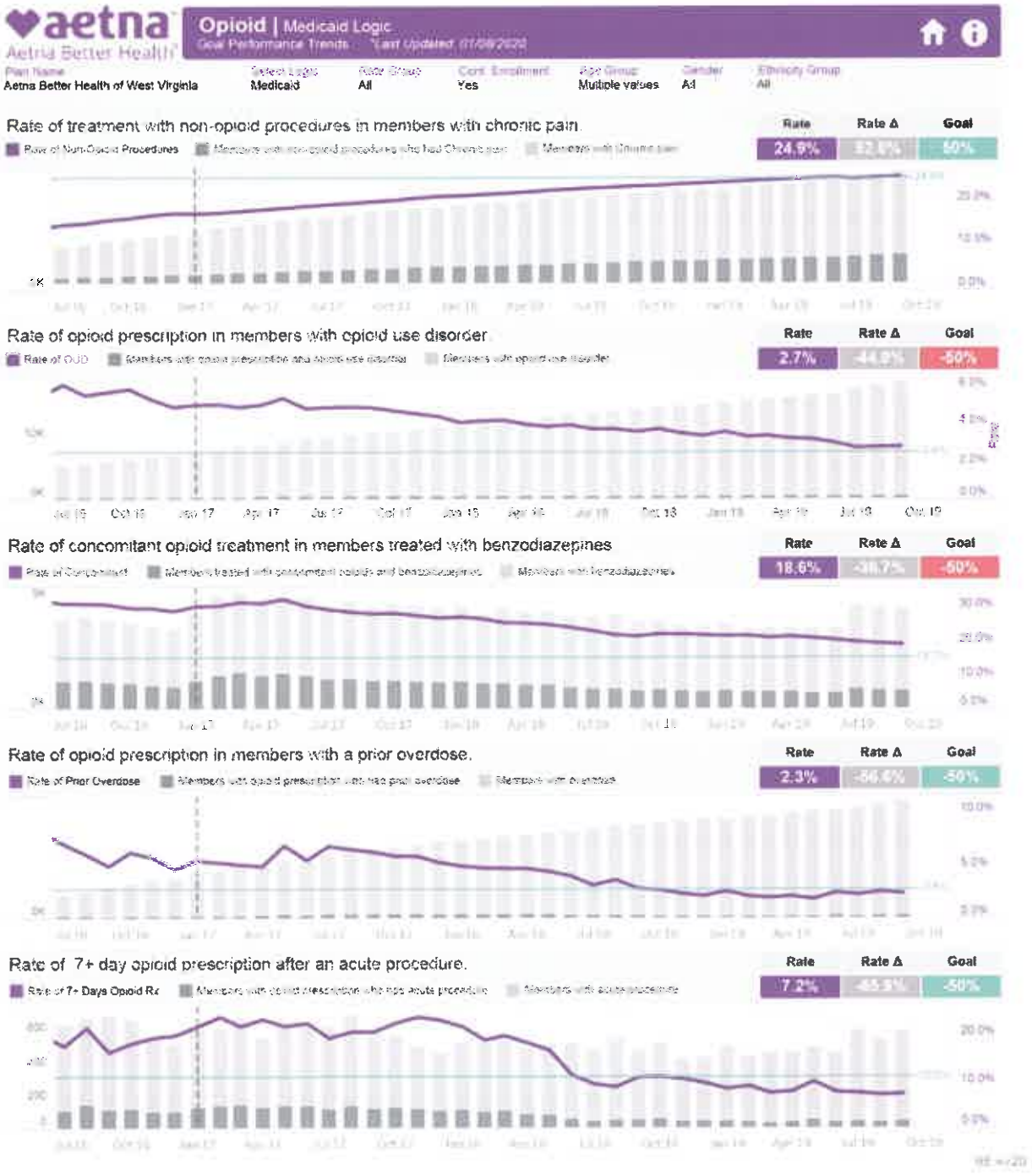


Figure 6.3.1-6: West Virginia Opioid Management Dashboard Indicators
Our Opioid Dashboard monitors progress towards our target goals relative to opioid management in West Virginia.

Aetna focuses on the following actions in support of this strategy:

- Monitor, mitigate, and prevent prescription abuse and miss-use
- Care management that connects members struggling with prescription drug abuse to care that is best suited to their needs and helps with SDOH needs including transportation
- Honor best practices and promote best outcomes through implementation of innovative programs
- Maximize harm reduction activities

Monitoring, Mitigation, and Prevention of Prescription Abuse and Misuse

Aetna engages in robust monitoring of multiple data points to identify and mitigate polypharmacy and prescription drug abuse trends. One key element of monitoring is **identification of concerning utilization or prescribing patterns as early as possible.** With actionable data we can mobilize quickly to mitigate problematic trends. We also create targeted education for members and providers to prevent or reduce polypharmacy and prescription drug abuse.

Monitoring

The Consolidated OUD Care Management Report is a monthly report (with a rolling three-month look-back period for paid claims) that calculates a total severity index based on these qualitative indicators:

- Number of controlled substance claims, with count of number of providers and pharmacies attached to these claims
- Cumulative morphine equivalency daily dose (MEDD)
- Number of naloxone claims
- Duration of overlap between opioid and benzodiazepine claims (concomitant days)

Care coordinators can review aggregate and individual member claims detail through this report. Additionally, Aetna runs other reports to identify potential concerns, which are also available to care coordinators monthly. These include the following:

- Individual reports of members filling or attempting to fill prescriptions for stimulant medications, antipsychotics, narcotic antagonist, opioid dependence medications (such as Suboxone), and opioids
- Drug utilization review report received from the Department
- Emergency room high utilizer report
- High-prescribers reports identifying the top prescribers by drug cost

- High-utilizer reports identifying members with 10 or more prescriptions in the past 30 days, OR members with 3 or more prescribers for prescriptions in the past 30 days
- Prescription opioid high-utilizer report identifying members filling 10 or more opioid prescriptions from 4 or more prescribers filled at 4 or more pharmacies in the date range specified
- Opioid and/or Suboxone® use in pregnant members
- Monthly CORE predictive model to identify at-risk and rising-risk members based on diagnostic flags for SUD or OUD

Mitigation Actions

Aetna takes several actions to address polypharmacy and the potential for prescription drug abuse when it is identified. If a particular provider has been identified with abnormal or problematic prescribing patterns, we refer the situation to the state's pharmacy director. CM and UM may also submit internal quality of care referrals for outlier prescribers. Our Quality team reviews these referrals and provides recommendations for appropriate actions. The Care Management team follows up with these recommendations when called upon. Aetna may engage in additional provider-related mitigation actions such as peer-to-peer reviews. At other times, our Special Investigations Unit (SIU) may be notified of a prescribing pattern concern and all Aetna internal departments (e.g. CM, UM) support the SIU in the investigation and identification of resolutions/solutions to address the allegation.

The following list demonstrates several other actions Aetna takes to prevent/reduce polypharmacy and/or abnormal prescribing patterns:

- Beginning in 2016, Aetna then-Executive Vice President and Chief Medical Officer Dr. Hal Paz, MD, began sending letters to the top one percent of opioid prescribers (within their respective specialties) to alert them of their prescribing patterns. Educational materials regarding prescribing for chronic pain were distributed to opioid super-prescribers. We have a dedicated email address for prescribers to respond to these letters and to obtain additional information.
- Through our controlled substance use program, Aetna monitors if a member receives multiple prescriptions from different prescribers or is filling them at numerous pharmacies. Depending on the situation, Aetna may send a letter to the prescriber and member, while also referring them to a specialist.
- Care management acts upon findings of monitoring reports via interventions with members as described later in this response.

- Engagement at the community level by collaborating with government and local law enforcement representatives to combat the epidemic through monthly meetings with the state Medicaid director to discuss trends and solutions

If Aetna were to be responsible for direct management and oversight of pharmacy benefits in West Virginia for MHT/WVHB/WVCHIP, we would look at practices we use across the country to implement additional safety and mitigation strategies as described here. Aetna's pharmacy director works with our pharmacy benefit manager and our clinical staff to enhance our member and provider pharmacy experiences. This collaboration optimizes member outcomes by ensuring access to safe and clinically appropriate medications and providing innovative support to members, prescribers, and pharmacies. We use a systematic, ongoing process to review the prescribing and dispensing of medications that preserves member access to clinically appropriate medications. Our approach involves a comprehensive review of the member's medication history before and during dispensing to achieve an appropriate therapeutic regimen and positive outcomes. Aetna utilizes evidence-based, quality-driven practices and safety messages at the pharmacy to decrease waste and harm to members. Our point of sale (POS) system utilizes computerized algorithms built into claim adjudication that sends soft alerts and hard-block alerts to pharmacists that prevent dispensing medications without further review and/or action by the dispensing pharmacists. These blocks enable us to certify appropriate utilization, safety, and avoid duplications.

Aetna implemented numerous SMART prior authorization (PA) edits in 2017 and 2018, which consider the member's pharmacy claim history and medical diagnosis (which is loaded from Aetna's medical claims adjudication system) and the prescriber's specialty type in the evaluation of prescribed medications at the POS. The use of pharmacy and/or medical claims history to adjudicate drug claims that would standardly reject at point of service and require PA allows a

member quick access to the medication and eliminates unnecessary delays when the member presents the prescription to the pharmacist. The following SMART PA POS edits used by Aetna to improve safety of medication use while easing the burden on the prescribing provider using known information and pharmacist actions include the following:

- Long-acting opioids; SMART edits to bypass PA for diagnosis of cancer or palliative care
- Morphine Milligram Equivalent (MME) dose edit for opioids except buprenorphine product; SMART PA MME edit bypass PA if diagnosis of cancer and palliative care
- Vivitrol® access with ICD-10 for OUD
- Naltrexone concurrent use with opioids requires diagnosis code F10.2 and F11.2
- MME dose edit exemption if diagnosis of burn diagnosis (T20.2-25.7) or sickle cell crisis

Education Aimed at Prevention

Aetna offers education to members and providers regarding prescription drug abuse and polypharmacy. Examples include the following:

- Providing education to members on dangers of prescription drug abuse and the availability of alternative therapies for pain relief on our preferred drug list
- Provider education on medical necessity and referral back to the National Opiate Prescribing Guides from Centers for Medicare and Medicaid Services
- Delivery of materials entitled "If at First You Don't Prescribe" for providers and the companion booklet for members, "Power Over Pain," which is part of our comprehensive educational campaign aimed at providing education for both providers and the public on the treatment of pain
- Outreaching to dental providers about members utilizing more than three days' supply of opioids. In 2019, 242 dental prescribers received letters and education, which resulted in a 70 percent reduction in prescriptions greater than a three-day supply measured three months post-outreach.
- Standard member newsletter guides on pain management, prescription management, and MAT for regular distribution in West Virginia
- Clinicians and health plan medical directors take mandated SUD American Society of Addiction Medicine and Mental Health First Aid recognition and treatment training; training also includes the use of screening for trauma, such as adverse childhood experiences, as it is critical for members' comprehensive integrated care. Relias training includes content on opioid addiction, trauma, and addiction training. CM staff attend state-sponsored in-service trainings.
- Aetna's rising risk assessment (described earlier in our response) identifies individuals potentially at-risk for SUD/OUD, and we provide these members with early intervention to prevent misuse and abuse. Our peer support specialist, who has lived experience with SUD, provides education and referral for social services for these at-risk members.

Care Management for Members with Historical/Current Prescription Drug Abuse Issues

While the prescription drug abuse crisis in West Virginia can seem daunting at times, **our CCTs possess the knowledge and optimism to help members struggling with these issues attain sobriety and healthier ways to manage pain**. Upon enrollment and throughout the screening, assessment, care planning, and ongoing care coordination process, members are evaluated for the potential for (or current indicators of) prescription drug abuse based on historical information or ongoing review of reports and risk indicators previously mentioned. Identification of these members includes review of data which demonstrate high average MEDD, concurrent opioid and benzodiazepine use, use of a controlled substance with a history of dependence, abuse, or overdose, or multiple prescribers (doctor shopping), to name a few. Members identified with a prescription drug abuse problem are assigned to Tier 3 intensive care management and receive the support of their local CCT, which includes a dedicated nurse or licensed independent clinical social worker care manager who has extensive training and experience related to SUD and OUD. **Aetna's regional CCTs also tap into the expertise of our peer support specialist**. The peer support specialist, who has successfully overcome their own SUD, can participate in care planning with the member and care coordinator, and offers sponsorship and support through telephonic and face-to-face contacts with the member.

Our care management model is tailored for members with prescription drug abuse concerns. Care planning for these members may include some or all of the following elements:

- Inclusion of Screening, Brief Intervention, Referral to Treatment (SBIRT) by providers through increased promotion of available training and coverage
- Increased availability of alternative therapies for pain relief such as physical therapy, chiropractic/osteopathic manipulative treatment, acupuncture, massage, cognitive behavioral therapy, and other effective alternative modalities
- Commitment to enhancing access to evidence-based treatment options for our members such as MAT. Aetna is collaborating with providers to increase adoption of MAT by providing

education, technical support, and promoting adoption through value-based contracting and the identification of quality MAT providers.

- Identification and resolution of factors related to SDOH, which may impact access to or utilization of available SUD services
- High ER utilizer reduction program: Care coordinators who identify one of their members on the high ER utilizer report outreach the member to identify the root causes for frequent ER visits and to develop a plan to help the member identify and use service alternatives

Intensive Care Management through The NAS Program

Andrew's mother, Tanya[21] had received SUD treatment for several years related to addiction to opioids, which she used as a means of self-treatment of a previous back injury. Her previous SUD treatment had not been successful, and she relapsed a few times. CPS had been involved with Tanya and her other children as a result of relapse and the death of her youngest child due to Sudden Infant Death Syndrome. When she learned she was pregnant with Andrew, she began taking Subutex through a local MAT program and was enrolled in intensive care management with Aetna at 27 weeks gestation. She had missed some appointments earlier in the pregnancy and was worried about her ability to retain custody of Andrew once he was born. The intensive care manager helped her access reliable transportation for services and helped her obtain infant supplies for the home. Tanya remained clean for the remainder of her pregnancy, with the help of her care manager, the MAT program, and her therapist who helped her address previous trauma. When Andrew was born, he was observed and treated in the Neonatal Transition Unit for one month. The care manager remained involved upon Andrew's discharge home and connected the family to Mountain State Healthy Families and an evaluation with Birth to Three for additional support. Tanya received in-home parent education until Andrew was six months old. Tanya now schedules and attends her appointments, using available transportation services. Andrew is now thriving at eight months old and is up to date on all immunizations and well-child visits with his pediatrician. Tanya invites the care manager to Andrew's well-child visits so the care manager can see his progress. Tanya reports that she has learned a lot and now feels worthy of being Andrew's mother.

- Medication reconciliation to evaluate issues and concerns about polypharmacy through a collaborative systematic process; member information is acquired and reviewed to assess the appropriateness of medication therapy, and medication-related problems are addressed. The member's medication record is available to the member (if appropriate). The person-centered care plan is updated to reflect the list of actions to resolve medication-related problems identified during the medication reconciliation process. The clinical pharmacy advisor provides education and medication adherence counseling. The collaboration and intervention from the clinical pharmacy advisor and CCT members are documented in the member's care plan, allowing for tracking and follow-up on any unresolved medication-related issues.
- Pharmacy restriction program: To the extent that managed care organizations could or would have pharmacy benefits management responsibility in the future, we could implement member

[21] Not their real names

restrictions to a single pharmacy and/or possibly a single prescriber due to attendance at MAT or identification as being at high-risk for SUD (need would be identified via pharmacy metrics as well as medical management reports of high ER utilization, overdoses, hospitalizations, and others).

Best Practices Initiatives and Outcomes

We have instituted several programs and best practices with impressive outcomes for our members who struggle with prescription drug abuse and/or related SUD/OUD. These programs include our NAS care management program, the Aetna Awesome Doctor program, and TIC, to name a few.

Moms and Babies Neonatal Abstinence Syndrome Program

We screen and identify pregnant women who are at risk for giving birth to opioid-dependent babies. Through an assigned care manager on the local CCT, we provide access to specialized high-risk care management through our NAS program. Specialty care managers, such the obstetrics specialists, are **embedded in neonatal intensive care units** for immediate response to pregnant women and their at-risk babies as part of the larger regional CCT. NAS program care managers coordinate needed SUD services for members. Our NAS care management program also includes the following elements:

- Members enrolled in the NAS care management program receive education, and support. Enrolled members who complete the NAS program can receive a Cribette® (portable crib) or baby carrier after delivery.
- Babies affected by NAS are enrolled in care management and followed for up to one year. The care coordinator offers education and support and tracks milestone development. Infant members enrolled in the NAS program can receive a milestone development toy after graduation from the program.
- Care coordinators are onsite at MAT facilities with the ability to meet pregnant members face-to-face when they come in for treatment. Our care coordinators are currently embedded in MAT practices in the central, southern, and western regions of the state.

As part of our commitment to collaborating with community stakeholders to support members battling opioid addiction, we engage the services of Lily's Place. **Lily's Place** opened in Huntington (Cabell County) in October 2014 as the first NAS center in the nation. Lily's Place provides observational, therapeutic, and pharmacological care to infants suffering from prenatal drug exposure. The facility is designed to make weaning as comfortable as possible in a quiet,

low-stimulation environment. Importantly, it offers non-judgmental support, education, and counseling services to families and caregivers. Aetna collaborated with Lily's Place to support the goal of allowing infants to remain in custody of their birth parents rather than entering the foster care system. Lily's Place works closely with our care managers who follow the mothers through delivery and then into Lily's Place if the child needs additional care. Our care managers meet face-to-face with the moms and spouses (if present and approved by mom) and develop a plan of care and follow-up. The care manager will follow infants for at least a year or more, as needed. **Prior to the implementation of our NAS care management program, only ten percent of babies remained with their birth mother. We have since made significant improvements in these outcomes through our NAS care management program:**

- In 2018, 59 percent of moms stayed in engaged in opioid treatment and/or counseling during pregnancy and through the first year after delivery
- In 2018, 82 percent of babies have remained with birth mom and were not removed from the home and/or placed in foster care
- For 2019, 87 percent of NAS mothers remain on opioid treatment and/or counseling during pregnancy and through the first year after delivery
- For 2019, 88 percent of babies have remained with birth mom and were not removed from the home and/or placed in foster care

Drug-Free Moms and Babies

Aetna and Drug Free Moms and Babies are developing a program with CPS to provide early intervention to mothers and babies affected by SUD This early intervention can help prevent children from being separated from their birth family and entering the foster care system by providing the birth mother support and assistance with locating necessary treatment programs. Aetna will offer care coordination and preventive approaches to improve the likelihood that the babies remain at home and avoid home removal or involvement in the foster care system, including continuity of therapies, support for social needs, and ongoing collaboration between the medical home, the social service system, and the member and circle of support.

Trauma-informed Care

We understand that, frequently, a history of trauma can be the root cause of a member's presentation with SUD or OUD. As a result, our care management approach is infused with TIC principles. Although the effects of trauma are detrimental, we know that trauma is treatable. Aetna's approach provides evidence-based, trauma-informed treatment and recovery services based on the universal precautions model that serves each member as if they had been traumatized. As a trauma-transformed organization, we ensure both Aetna staff and provider organizations have the training and resources necessary to deliver service through a TIC lens. Aetna has collaborated with the National Council for Behavioral Health to deliver this training. The next training is scheduled for February 2020.

Aetna's Awesome Doctor Program

Aetna's Awesome Doctor is national program we have added to value-based services outcome goals. Providers participate by completing education about how to treat pain safely, how to screen patients for OUD, and how to provide/refer for services. The educational program encourages providers to consider the 'disease of addiction in care model.' Providers who complete the program receive public recognition and peer comparisons and can be recognized for participation in Aetna News. The Awesome Doctor program has been highly successful in our Florida Healthy Kids market and is an excellent tool to inform communities of best practices and high-quality providers. We plan to implement this program in West Virginia to highlight providers who take these steps to be more informed.

Care Management Opioid Program Champion

We have a new dedicated position, the care management opioid program champion, on our West Virginia Care Management team. The care management opioid champion is a care manager responsible for supporting, communicating, and coordinating the goals and objectives

of the Aetna Medicaid care management opioid program and all CM opioid-related initiatives. The opioid champion serves as a point-of-contact for opioid-related care management projects, questions, news, and communications from corporate leadership. They monitor state contract, rules, and regulations related to the opioid management program's care management service requirements for updates and changes. They have a collaborative working relationship with the pharmacy director at the plan to improve communications between the departments, and they attend the quarterly Opioid Steering Committee.

Aetna was proud to provide $400,000 in impactful financial support to PROACT to advance SUD treatment in the Charleston-Huntington region. PROACT is a large community-based organization with collaborating institutions including Cabell Huntington Hospital, St. Mary's Medical Center, Marshall Health, Thomas Health and Valley Health. PROACT offers MAT/SUD treatment, peer support, job placement, and referrals to other services to address the clinical, behavioral, spiritual, and employment needs of people affected by the epidemic of substance use.

Harm Reduction

In addition to identification and prevention, targeted care management, and the use of best practices to address prescription drug abuse, Aetna takes further steps towards harm reduction. Beginning in March 2020, our **Lock it Up program** will be used to support safety by providing members with a lockbox to secure their medications. This is a national initiative and is kicking off in West Virginia in 2020 as one of our value-adds. The value-add includes a secure lockbox for any member who is prescribed ongoing opiates and/or multiple high-risk medications with education on harm reduction and avoiding accidental overdose or misuse as well as disposal information and emergency numbers for access. For members in care management, the care coordinator makes the referral to obtain the lockbox and provides education to the member regarding the importance and reasons for its use. For members not in care management, Member Services or providers may make the referral to obtain the lockbox. Additionally, 29 of

our 57 CVS Pharmacy locations offer a full-time **drug disposal unit** onsite. For stores without disposal units, beginning in 2020, CVS Pharmacy will provide DisposeRx packets at no cost to patients who are filling an opioid prescription for the first time.

Approach to Population Health

CM054	The Vendor should describe its population health approach including, but not limited to, the following:
CM055	Engaging members across the entire care continuum
CM056	Promoting and incentivizing health behaviors and disease self-management
CM057	Integrating Care Management
CM058	Advancing evidence-based practices
CM059	The Vendor should describe its process to evaluate the member population and coordinate prevention and wellness programs available to all members.
CM060	The Vendor should describe its process to collect and maintain member self-reported demographic, social determinants, and health needs assessment data for aggregate use in, at a minimum, population health management, network adequacy determination and quality improvement activities

[CM054] Adapting to the changing landscape of health care, **Aetna has responded to the needs of our members by expanding our focus to include population health improvement, SDOH, and primary prevention to promote health and well-being among our members.** Aetna's person-centered PHM program facilitates enhanced quality of care and effective management of the health of defined populations by empowering members to engage and drive their health care to improve their health outcomes. The elements of our program are in alignment with National Committee for Quality Assurance's (NCQA) PHM model and standards. Aetna has completely integrated the NCQA PHM standards into the fabric of our PHM plan. The PHM program, supported by our SOC, is integrated with our value-based purchasing (VBP) programs, and supported by our use of powerful analytics to deliver actionable data to support member identification and risk stratification. Our VBP program is aligned with our PHM strategy to advance improvements in the delivery of quality, access, and evidence-based services with the goal of improving the health of our

member population as a whole, and for specific subpopulations as well. Our VBP arrangements are designed to align with Department-specific quality and performance goals to optimize outcomes and results. As part of our VBP program, Aetna uses predictive modeling reports, gaps in care information, claims data, and provider input to target member-level intervention related to emergency room utilization, inpatient admissions, and risk for readmission.

[CM055] Engaging Members Across the Continuum of Care

Aetna embraces a 'no wrong door' approach to PHM. Members may self-refer or be referred through outside entities. Regardless of the way a member chooses to access care, their level of need is assessed upon enrollment and throughout the course of their care through a variety of touchpoints, including interactions with their local CCT, connections with embedded care coordinators at their doctor's office, or through community providers and organizations who collaborate with Aetna in service delivery throughout West Virginia. **Aetna's population health management strategy focuses on prevention, predictive risk, early identification of rising risk, and evidence-based care.** Our evidence-based, member-centered screenings and assessment provide us with a deep understanding of our members and their needs from a holistic perspective. We assess members' goals and aspirations to improve their opportunities for independence, self-determination, and self-management. Additionally, provider gaps-in-care reports (which are also sent to our value-based services providers) identify members on a provider's panel in need of a health screening or preventive exam. Information can be filtered to examine their performance by provider, by location, and for each member. This helps us target outreach for members who need more support and care. From there, members are actively engaged by their dedicated, local care coordinator throughout the care planning and service delivery process as we support them in the attainment of their health goals.

If a gap in care has been identified, the care coordinator may conduct more targeted condition-specific assessments and/or may refer to one of the condition specific self-management programs described throughout our response. For example, we offer incentives to pregnant members to attend prenatal appointments to prevent gaps related to prenatal care. As another example, when our QM department identified a trend that mothers were not attending postpartum visits, our CCTs engaged in additional postpartum outreach efforts. This resulted in **improvement in the postpartum visit rate from 60.83 percent in 2017 to 63.50 percent in 2019**.

[CM056] Promoting and Incentivizing Healthy Behaviors and Disease Self-Management

We have expanded our service model to serve all populations, focusing not on disease but rather on helping members achieve their health and wellness ambitions. We seek to engage individuals who otherwise are not engaged in their health care, including those on the continuum of care with few risk factors and rising risk, to change West Virginia's health care culture and to align with the Department's goals. **The Aetna Medicaid PHM strategy is a personalized approach that emphasizes empowering members to achieve health goals by recognizing and elevating the individual's expertise and central role in their own health.** We emphasize the importance of benefit education, including appropriate health actions, with every interaction with both members and providers. We use several tools to remind our members and their circles of support about important aspects of their care. When a member calls our Member Services team, our staff can provide real-time reminders from our gaps-in-care report for needed services. In addition, we conduct live outbound calls to help members to understand what care they may need, including preventive services and chronic condition management. We use targeted, direct mailings to remind members to access services according to recommended screening and assessment schedules. For example, **we send a direct mailing to members**

that includes growth charts for young members with attached well-visit and vaccine schedules. These mailings are sent to families of five- and six-year-old members who have not yet had a well visit. We also provide reminders to obtain immunizations during flu season. We use disease management newsletters and condition-specific patient education materials, including topics such as diabetes and asthma management. Our text program sends personalized text messages free of charge to program members and their families/circles of support who wish to receive them on a variety of topics, including the text4kids program, which provides reminders about well child visits (i.e., exams for children timed to their age).

Wellness services focused on preventing illness and injury, promoting health and productivity, and reducing risk are provided to members through our offering access to ActiveHealth Management's (AHM) health appraisal and self-management tools. AHM is a contracted vendor that is NCQA Wellness and Health Promotion-accredited.

Health Appraisal: Adult members have access to AHM's online, telephonic, and printed health assessment. The results of the health assessment summarize the member's risk factors and wellness profile and identifies opportunities for participation in targeted population health programs and services. Information is provided to the member on specific health behaviors changes that will reduce the member's risk factors. Aetna staff contact members based on their identified risks and conditions to offer targeted population health programs and services.

Self-Management Tools: Aetna provides member access to AHM's online materials and interactive videos on multiple wellness and health promotion topics, including smoking and tobacco use cessation, nutrition, and managing stress. The materials are also available in print. Members can set wellness goals and track their progress through online tools.

We offer a number of programs and incentives to promote healthy behaviors and member self-management of disease, as described previously, with respect to prenatal and postpartum care, NAS programs, diabetes screenings and education, and participation in healthy living programs (like Ted E. Bear, M.D.℠ Cub Club), to name a few. Table 6.3.1-5 provides additional information regarding member some of our other incentives to promote healthy member behaviors and condition self-management.

Table 6.3.1-5: Other Incentives to Encourage Member Healthy Behaviors and Disease Self-Management

Incentive Name	Description
Congestive Heart Failure (CHF) Program Reward	Enrollees with CHF receive digital weight scales and a weight tracking log to monitor progress with their PCP and care coordinator.
Asthma Care Program	Members with asthma who enroll in our asthma education program (with our certified respiratory therapist) will receive a peak flow meter, which measures and monitors asthma symptoms.
Dental Care for Members with Diabetes	Through our relationship with the West Virginia University Dental School, enrollees age 21 and older, diagnosed with Type 2 diabetes, and living in particular counties, can receive routine dental care that includes two exams, two cleanings, and bitewing X-rays each year.
Well-child Visits and Pediatric Dental Care	Members can earn a $25 gift card for completing a well-child exam for children aged 12 to 18 and members aged 2 to 3 who complete dental check up with a dental practitioner will earn a $25 gift card to encourage early dental care.
Adult Walking Program	Members 18 and older who enroll in our eight-week program receive a pedometer and walking/steps tracking log; those who complete the tracing log through the end of the eight weeks receive a $25 gift card.

[CM057] Integrating Care Management

Aetna employs a stratified approach in our population health and care management model. Members enrolled in care management are stratified to high-risk, medium/rising risk, and low-risk level as indicated by their known risk factors:

- Low risk (Tier 1: population health care management): Most members (86.7 percent) are identified as low risk. These members have minimal gaps in care, limited ER or inpatient utilization, few prescription medications, or have reported that they do not require a higher level of support. These members receive health promotion interventions focused on maintaining health and keeping risk low, such as annual visits to their PCP, recommended screenings, and self-management tools. The area of focus for low-risk members and programs directed toward them is keeping members healthy.
- Medium risk and rising risk (Tier 2: supportive care management): A proportion of members (5.3 percent) are identified as medium and rising risk. These subpopulations include members with chronic conditions like asthma or diabetes, behavior health concerns, high-risk pregnancy, and other special populations. These members have not yet exhibited high-risk utilization trends but likely may in the future if left unmanaged. These members receive disease management education materials and programs, supports to access health services effectively, and care management outreach at a minimum quarterly. The area of focus for medium-risk members and programs directed toward them is primarily managing emerging risk, but also includes keeping members healthy, managing multiple chronic conditions (diabetes and heart disease), and outcomes across settings where members require support to coordinate care.
- High risk (Tier 3: intensive care management): A proportion of members (7.8 percent) are identified as high-risk. These members may frequently utilize the ER or have had multiple inpatient admissions and/or may require high-risk, high-cost medications. They may have multiple chronic and/or disabling conditions like SUD and serious mental illness. High-risk members may require the highest level of resources from complex care management in addition to disease or condition management support and preventive care programs. The area of focus for high-risk members and programs directed toward them is managing multiple conditions (diabetes and heart disease) and outcomes across settings.

[CM058] Advancing Evidence Based Practices

Aetna's PHM programs follow from a locally rooted understanding of population health priorities, needs, and assets while having the underpinnings of a national structure driven by population data analytics and evidence-based practices that focus our PHM activities for distinct member populations throughout the continuum of care. Aetna encourages the use of **evidence-based clinical practice and preventive services guidelines** by our practitioners and providers. Guidelines are available on demand in the online provider portal and posted on Aetna website and are adopted from nationally recognized sources and peer reviewed medical literature. Providers are informed of the availability of new guidelines via updates posted on the provider website. Providers may request a copy of a guideline at any time by contacting their provider

representative or the office of the chief medical officer. The guidelines cover various conditions such as asthma, diabetes, coronary artery disease, and chronic obstructive pulmonary disease. They also address other topics such as medication management, prenatal care, and dental services. Additionally, Aetna promotes evidence-based practices through the development of **Clinical Policy Bulletins** that are created, reviewed, and updated annually by a dedicated medical team looking at the latest recommendations from specialty colleges, latest studies, and standards of care and that are available online.

[CM059] Evaluation of the Population and Coordination of Prevention and Wellness Programs

Aetna integrates a range of data sources, systems, care sites, and domains to identify member populations and sub-populations, understand their care needs, and operate programs designed to help meet those needs. Enrollment data is received from the Department and is integrated into Aetna's member databases and aggregated to quantify the basic demographic and benefit program eligibility category across all plan membership. This data set is used to complete the annual membership profile in order to monitor population characteristics and changes in terms of geographic distribution, age, sex and race/ethnicity distribution, language preferences, cultural diversity trends, and changes in rate-group and within the health plan membership.

Recent annual population health assessments led to Aetna's development of enhanced care planning modules, our "Healthy You, Healthy Baby" guide, pre-diabetic screening programs through the National Diabetes Prevention Program, and our collaboration with Cabin Creek and Marshall to provide coordinated care for at-risk youth, to name a few.

After the membership profile is generated, the enrollment data set is integrated with medical, behavioral, and pharmacy claims data and lab results. Together, these data sources make up the key data elements necessary to run the General Risk Model, which is a component of

identification of targeted populations for certain PHM programs. Risk stratification, medical, behavioral and pharmacy claims data—and in the cases of immunization records, member pregnancy identification, certain chronic conditions such as HIV/AIDS, and OUD, state registries or file feeds—are integrated with HEDIS gap in care identification for members missing recommended services. The presence of conditions, medical utilization trends, certain pharmacy utilization or trends, and/or open gaps in care together with membership profile characteristics based on these data sources indicate eligibility for targeted PHM programs that focus on members with specific conditions. The membership profile analysis, which integrates data from the state enrollment file and medical, behavioral and pharmacy claims, and lab results as described above, initiates the population assessment process.

The annual population assessment is performed by Aetna's Quality Management department to provide a comprehensive assessment of the West Virginia MHT population (to include WVCHIP in the new contract). Assessment results are used to understand membership population characteristics and care needs and ensure that that these are met at the highest levels. These needs include provider accessibility and availability, translation services, wellness and preventive health services, services for members with multiple or specific chronic conditions or severe injuries, community-based service resources, and continuity and coordination of care. Population assessment results inform PHM programs including prevention initiatives, self-management programs, performance improvement activities, integrated care management, and other quality initiatives that are implemented to meet member needs. These programs support cost reduction, improve health outcomes of the population, and help individual members achieve their personal health goals. The programs are intended to serve the specific needs of each group within the population. Member programs are targeted according to members'

individual risks as identified through stratification and/or member responses to individual assessments. Programs and activities directed towards practitioners or providers and across systems of care are designed to support delivery of care and resources in accordance with population and individual needs.

Each PHM program includes defined and measurable goals that are used as indicators of program effectiveness; these goals are defined within each program description. Program impact is regularly monitored and evaluated annually to determine whether the activities completed produce the stated goals within the targeted populations groups. Program evaluation results drive further analysis to identify areas for improvements or changes as needed where goals or population needs are not met. Aetna follows an analysis procedure that stipulates metrics and means of evaluation of the execution and impact of its PHM programs collectively across four focus areas. The analysis is a comprehensive document connecting the PHM strategy and evaluation by reporting performance on program goals collectively and supporting the determination of whether program activities were completed as planned and resulted in intended outcomes. As Aetna's goal is to improve and/or maintain health outcomes for the served membership through the development and deployment of its population health strategy, it is imperative to perform a multifaceted analysis looking at different aspects of the population and plan impact. Aetna selects the most appropriate, evidence-based, meaningful, and impactful measures for each program to ensure that ongoing program development can be implemented in an efficient and effective manner while keeping members at the center. Measures are selected to align with the objectives of the programs for the target population, such measures that include, but are not limited to, NCQA's HEDIS performance datasets and SF12® outcome surveys. We evaluate program-specific utilization trends and/or associated

costs that are relevant to the objectives of each program. We also assess our performance by obtaining feedback from members to confirm the characteristics and needs of the member population drive the implementation of an effective PHM strategy. Based on the results of the annual multifaceted quantitative analysis, we identify opportunities for improvement that inform development and implementation of programmatic changes.

[CM060] Collection of Data for Use in Population Health Management, Network Adequacy Determination, and Quality Improvement Activities

Aetna collects demographic, SDOH, and health related information reported by members during the HRQ, ORQ, HCE and other assessments to improve the health status of our members. Demographic, SDOH, and health assessment data is reviewed at the aggregate level to inform PHM, network adequacy determination, and quality improvement activities. Care management works in concert with SOC administrators and the Aetna Network and Quality Management (QM) departments to review all available data to identify gaps and solutions to resolve these gaps. For example, the Service Improvement Committee (SIC [a sub-committee of our Quality Management Oversight Committee]) includes members of the care management, network, and QM teams. **The SIC reviews available population health data to make recommendations that resolve network adequacy or service gap concerns.** Additionally, the QM department examines available data to design **Performance Improvement Projects** that result in population-specific projects which aim to meet measurable performance objectives to improve overall service delivery and outcomes. For example, when the data showed that only 61 percent of members aged 2 to 20 attended an annual dental visit, the QM team pinpointed the geographic areas of highest concern and collaborated with Provider Relations to host dental clinics in those areas. Parents and guardians who brought children to these events received a $25 gift card. Additionally, care management teams mobilized in those areas to provide

additional education and outreach regarding the importance of dental services and our Community Development team focused attention on the importance of dental visits during their back-to-school events in various communities across the state. Aetna also collaborated with Head Start programs in Raleigh, Mercer, McDowell, Monroe, and Wyoming counties to highlight the importance of dental screening visits. As a result of this multipronged approach to enrollee outreach, the dental visit rate changed from 61 percent in 2017 to 64 percent in 2019 (a statistically positive change). Care Management, Network, and QM departments rely on data from the following sources described (most which are originally derived from member self-reported demographic, assessment, and SDOH information) to make decisions regarding PHM, network adequacy, and quality improvement projects.

Stratification of SDOH information: In 2018, Aetna began stratifying member reported SDOH data across demographic characteristics to identify populations with health disparities. We are continuously developing new ways to stratify social determinant data to identify disparities and learn from best practices developed in Aetna health plans across the country. This stratified data helps us target interventions to improve population health. Our approach to the collection of data includes collection of both individual-level, self-report, claims data, and internal and publicly available population-level data. We analyze this data annually; it informs the development of our proprietary Regional Health Profiles, Population Assessment, and Membership Profile, where specific references to West Virginia member food, housing, transportation, and personal safety/domestic violence are addressed.

General Risk Model™ (GRM): Aetna's proprietary risk assessment application. GRM, identifies members who currently have or are at risk of developing complex and/or chronic health care needs. The GRM accomplishes this task through an internal diagnostic grouping process that

evaluates over 15,000 ICD-10 codes, including behavioral health codes and DSM-IV diagnoses, to identify specific chronic and acute conditions having long recovery timeframes (such as spinal cord injuries, chronic mental illness, or SUDs). The goal is to accurately identify chronic conditions that informs the care needed by each member.

CORE: As described earlier in this response, we also use a proprietary, evidence-based process called CORE to provide further refinement to our predictive modeling. CORE builds on GRM data-adding algorithms to prospectively identify members who are at risk for inpatient and/or emergency room utilization within the next 12 months.

Health Care Equity Dashboard: The HCE dashboard is a tool to analyze population health data to understand population characteristics such as race/ethnicity and how these correspond to geographic area, and prevalence of certain health conditions or of gaps in recommended health services. This tool informs planning activities to improve population health, quality, and care management interventions to address health disparities. The dashboard synthesizes Aetna's population demographics based on monthly member enrollment data, HEDIS data, and utilization data from medical, behavioral, and pharmacy claims. We use the tool to understand dominant population characteristics across these factors. The tool features several filters that users can apply to a number of reports meant to dissect prevalence and distribution of characteristics and factors across population groups. Available reports include the demographics dashboard, which segments benefit groups, age, gender, race/ethnicity, language, certain health conditions, and GRM category. Our demographic map dashboard displays a heat map of member distribution at the county level. Users can filter by the demographic factors previously listed and explore the geographic population distributions of filter selections. Users may also drill down to the ZIP code level within a county to explore

population distribution and concentration. The HCE dashboard allows analysis of HEDIS data through a HEDIS dashboard and HEDIS map dashboard. These reports allow analysis of groups to identify disparities in gaps in care based on geography and the demographic factors previously listed and presence of certain health conditions, including serious mental illness. The HEDIS map dashboard features a heat map visual representation of all HEDIS measure rates down to the ZIP code level using NCQA Quality Compass® national percentile benchmarks. **Table 6.3.1-6** provides an overview of some programs we offer as a result of our analysis of population health data mentioned throughout our response, as well a review of publicly available community health rankings and community survey data.

Table 6.3.1-6: Actions Taken to Address Regional Disparities

Region	Disparity	Aetna Program
North	• Food insecurity • Higher rates of uninsured individuals • Higher rates of depression • Higher rates of obesity	• Referrals to food pantries: We Feed People/Union Mission, Feeding America • Referrals to WIC/SNAP benefits • Community health fairs to educate about health insurance/plan benefits • BH care management specialist • Walking program/free pedometer; step-tracking log
East	• Higher rates of cardiovascular disease • Highest rates of chronic obstructive pulmonary disease within the state	• Online materials and interactive videos on smoking/tobacco use cessation, nutrition, and managing stress • Chronic Condition Management program delivered by local CCT • Tobacco cessation specialist on CCT • Referrals to Breathe2Relax app • Walking program/free pedometer; step-tracking log
Central	• Higher rates of depression • Higher rates of obesity • Higher usage of alcohol and excessive drinking	• BH care management specialist • Walking program/free pedometer and step-tracking log • Peer support specialist and SUD care management specialist to address alcohol and substance use
South	• McDowell County: prevalence of	• National Diabetes Prevention Program

Region	Disparity	Aetna Program
	diabetes (19.7%) and adult obesity (44.6%) • The preterm birth rate among African American/black women is 22% higher than the rate among all other women	• CHW and ICT at onsite FQHC for diabetes education, including home visits to coordinate the plan of care • Value-added Diabetes Oral Health program for members under the age of 21 who are diagnosed with Type II diabetes and the member lives in one of the 20 participating counties • Healthy Pregnancies, Healthy Babies program • Community outreach events: sponsored baby showers and health fairs • Safe Sleep initiative: Cribettes® incentive for prenatal visits; all staff are trained on the Safe Sleep and Keep Your Cool program.
West	• Higher rates of asthma • Higher rates of tobacco use in youth 12 and older • High mortality and suicide rates • High substance abuse and overdoses and excessive drinking • Higher incidence of NAS	• Access to AHM's online materials and interactive videos on multiple wellness and health promotion topics, including smoking and tobacco use cessation, nutrition, and managing stress • Asthma Care Program: peak flow meters; • SUD care management specialist • BH care management specialist • NAS care management program

4. Community/Stakeholder Engagement

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Community/Stakeholder Engagement (CS) as part of their bid. The Vendor's narrative response should not exceed 25 pages.

Aetna's Community Engagement team is an extension in the field of our health plan operation, interacting with community-based organizations (CBOs) and state agencies to gain information, resources, and referrals to better serve our enrollees. We have provided care and services to West Virginians in all 55 counties and created lasting, vibrant, and successful collaborations. We share a cultural richness that empowers us when addressing social determinants of health (SDOH), integration and quality of care, and outcomes for our fellow citizens. We strategically collaborate with organizations that most closely serve our enrollees.

We listen, we activate, and we create collaborative solutions together with community resources. Ingrained in communities throughout West Virginia for over 23 years, we understand and collaborate with CBOs from Bluefield to Weirton, Martinsburg, Ravenswood, and all points in between, listening to community needs. **We are West Virginians helping West Virginians through engagement of state and community resources and supports to facilitate opportunities for our enrollees to live their best lives.** Through extensive collaboration with community stakeholders, we gain deep understanding of the communities and those people we serve and receive insights on how to best meet Department for Health and Human Resources (Department) expectations and requirements.

Consistent, meaningful engagement with communities and stakeholders, both public and private, in every part of the state, is critical to our success in serving West Virginia's most vulnerable residents. **Our community development staff participated in over 1100**

community events and collaborative meetings in 2019 throughout the State. Based in part through our engagement with community resources and stakeholders, Aetna has identified within our health education plan key areas of focus for 2019 – 2020, including the following:

- Early and Periodic Screening, Diagnostic, and Treatment; Well-Child; and Adolescent Well Care
- Dental
- Childhood and Adolescent Immunizations
- Flu Vaccines
- Preventive Services for Women
- Prenatal and Postpartum Care
- Respiratory
- Diabetes
- Hypertension
- Nutrition and Obesity
- Tobacco Cessation
- Behavioral Health and Substance Use
- Appropriate use of Antibiotics

These are opportunities to make presentations and distribute materials on a variety of health-related topics that affect populations we serve. From these interactions together, we develop specific solutions to address community needs. As an example, we understand the health disparities of diabetes in Kanawha County and hepatitis B and C in the central region of the state. We act through effective collaborations, as identified in **Table 6.4.1-1** below, to address disparities, complex health concerns, and SDOH. Every engagement is intentional; every meeting and handshake has purpose to improve the health and well-being of the individuals we are privileged to serve.

Commencing with Chief Executive Officer (CEO) Todd White and across all levels of our West Virginia staff into our frontline teams, Aetna staff logs hundreds of volunteer hours each year as we place volunteerism and community support among our highest priorities. Aetna's goals include improving health and social outcomes for West Virginia's Medicaid population across the lifespan through person-centered holistic care approaches. Our engagement and tailored approach with **community agencies and resources** directly aligns with the Department's strategy and program objectives. We strategically reinvest our cost savings in programs that are

.

Table 6.4.1-1: Regional Approach to Community and Stakeholder Engagement

Region	Social Determinant of Health	Causes	Aetna's Collaborative Actions with Stakeholders
Statewide	• Food insecurity • Internet Access	• Large volume of food deserts • Poor internet access in many rural communities	• Mountaineer Food Bank (all regions): collaboration includes sponsoring multiple mobile food pantries and purchased Box Truck for food distribution throughout the state as well as student backpacks. Mobile pantries include locally grown fresh produce. • West Virginia Library Commission serves as internet access point in many communities • Collaborate with Women, Infants, and Children (WIC) on proper nutrition for children (prenatal through age 5)
North	• Higher rates of obesity • Higher rates of uninsured individuals	• Limited healthy food options • Limited to no access to physical activity	• Distribute healthy eating and activity information to schools to address childhood nutrition and obesity through Family Resource Network (FRN) • Participate in community health fairs in all regions: activities at these events include education about our plan, services, and benefits; disseminating health and wellness information; and addressing SDOH experienced by the community (i.e., food access) • Women's Wellness Clinic in Wheeling offering preventive exams including mammograms
East	• Low community attachment • Highest incidence of chronic obstructive pulmonary disease in the state	• A high number of individuals do not work where they live and associate with bordering states in lieu of local community • High tobacco utilization	• Aetna provides member access to Active Health Management's online materials and interactive videos on multiple wellness and health promotion topics, including smoking and tobacco use cessation, nutrition, and managing stress through community health fairs • Collaborate with WIC (all regions) on proper nutrition for children (prenatal through age 5) • Distribute information to parents of children in Head Start on wellness exams and healthy activity

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Region	Social Determinant of Health	Causes	Aetna's Collaborative Actions with Stakeholders
Central	• Higher rates of obesity • Higher usage of alcohol and excessive drinking • Acute hepatitis-B (HBV) and acute hepatitis-C (HCV) has increased 213% and 209%	• Lack of physical activity Lack of treatment for substance use and abuse	• Lewis County High School resource fair providing nutrition and information including tobacco use (vaping, tobacco, and smokeless) cessation, nutrition, managing stress, and substance use prevention • Walking program: members can receive a pedometer and log to track their steps and receive an incentive for completing the 8-week program
South	• Homelessness • Region has a high diabetes prevalence • Poverty rate above the state and national averages • Increasing rates of HBV, HCV, and HIV • Drug overdose rates above the national average • Infant health and safety	• Lack of affordable housing • Limited healthy food options • Limited employment opportunity • Lack of treatment for substance use and abuse and prevention programs • Poor prenatal care and parent education	• Covenant House, which provides homeless services in Charleston • Aetna partners with regional hospitals, public health departments, and a federally qualified health center associations (FQHCs) to provide diabetes education classes for our members • Value-added Diabetes Oral Health Program for members over the age of 21 who are diagnosed with Type II diabetes and live in one of the 21 participating counties • CVS Workforce Initiative to improve employment opportunity • Community events and health fairs: activities at these events include educating the community about our plan, services, and benefits; disseminating health and wellness information; and addressing social determinants of health • Involvement with various prevention collaboratives, such as Great Rivers Regional System for Addiction Care • Safe Sleep initiative: Cribettes® incentive for prenatal visits; all staff are trained on the Safe Sleep and Keep Your Cool program. Members receive educational materials.

working using contracting tools with data-sharing agreements and outcomes measures to best address what we know about individual communities and specific enrollee needs

Collaborative Approach to Department Agencies and State Advocacy Groups

CS001	The Vendor should describe its approach to establishing and maintaining relationships with associated Department agencies and State advocacy groups.

With deep rooted experience of West Virginia culture, we have a multipronged approach based on **listening to understand enrollee needs while tailoring our community and stakeholder engagement with a localized and focused strategy**. Our leadership team including Todd White, Aetna Better Health of West Virginia CEO, leads our engagement with the Department, its five bureaus, and other involved governmental entities, including the following:

- Bureau for Behavioral Health
- Bureau for Child Support Enforcement
- Bureau of Children and Families
- Bureau for Medical Services (BMS)
- Bureau of Public Health (BPH)
- West Virginia Children's Health Insurance Agency (WVCHIA)

Our approach to engaging state government agencies is one of collaboration to best serve our enrollees and the people of West Virginia, leveraging our experience in Medicaid managed care. We continue to seek ways to offer helpful assistance and innovative processes to aid the Department and its Bureau for Medical Services (BMS), Public Health, and Children and Families. Mr. White instills a collaborative, neighbor-helping-neighbor approach to create solutions for complex health concerns. In biweekly standing meetings with BMS, we collaborate with State staff to address emerging trends and potential solutions to best meet enrollee needs. Donald Gibbon, DO, our chief medical officer/medical director, collaborates with Department staff and other managed care organization (MCO) chief medical officers within standing meetings to improve and streamline medical processes across the Medicaid enrollee population. Dr. Gibbon and Frank Angotti III, MD, our behavioral health medical director, are intimately

involved in the **collaboration between Aetna and the BMS for the development of their opioid management plan and their Safe and Effective Management of Pain initiative.**

Under the new Medicaid and WVCHIP contract, we will engage and collaborate with WVCHIP

Collaborating with BPH. Aetna's community engagement director, in collaboration with our director of quality, meets with the BPH to maintain our strong, focused connection and to better understand the BPH perspective to create better overall wellness of the populations served. Our regional Care Coordination teams work to increase access to community supports to advance individual health outcomes and overall population health of our enrollees.

Aetna has decades of experience providing high-quality primary and secondary care, mental health, and dental care for all aged enrollees. We continue to strengthen our practice as we incorporate the remarkable changes in the provision of quality services for our enrollees to live their best lives. Our core innovations, which form the foundation of our model of practice for supporting enrollees, include complex care management and addressing SDOH. One such innovation we are currently implementing is a community health worker initiative in each region of West Virginia to engage community-based providers who serve enrollees with trauma, rising risk, toxic stress, and social isolation.

Collaboration with the BPH includes service to persons with diabetes. We emphasize serving individuals with diabetes in consideration of the fact that West Virginia's mortality rate is 53 percent higher than the national rate[1], and for this reason, we are also we are engaged with the Kanawha

[1] "Creating a Culture of Health in Appalachia," Appalachian Regional Commission: accessed January 19, 2020; https://www.arc.gov/images/appregion/fact_sheets/HealthDisparities2017/WVHealthDisparitiesKeyFindings8-17.pdf,

Diabetes Coalition. The coalition is a collaborative effort between CBOs, providers, and Aetna to create solutions to reduce diabetes rates for children and adults in Kanawha County.

Aetna partners with the State on community engagement to prevent and manage infectious disease. For example, through our collaboration with the Ryan White Foundation, our staff received training that enables referrals to assist enrollees diagnosed with HIV/AIDS

Aetna invests in the communities we serve with longstanding presence across West Virginia to uniquely leverage our understanding of communities that are geographically isolated and lacking in community resources. We are committed to assisting all West Virginians burdened by poverty, addiction, limited resources, and access, and other SDOH barriers. These are our communities, and we are their neighbors and service providers dedicated to focused, tailored, and data driven evidence-based solutions to best meet their needs.

We engage advocacy groups across West Virginia through collaborative efforts to optimize enrollee health access and outcomes at the direction of Aetna's community outreach director, Jim Smallridge, a registered nurse and West Virginia native. As a trained nurse, Mr. Smallridge has a unique perspective and leadership skills to engage community resources including at community events.

Aetna engages community stakeholders who serve community members across the lifespan. We interact with WIC and perinatal programs throughout West Virginia, including the Perinatal Partnership, in projects such as the Long-Acting Reversible Contraceptive (LARC) initiative. To further support women in prenatal care, Aetna's senior director of medical management and one of our medical directors participate on the Substance Use in Pregnancy Committee. To address the needs of SSI enrollees, we actively engage with disability-oriented stakeholders including the following:

- Appalachia Project: A program dedicated to helping with home repairs and building ramps for persons with disabilities
- Arc of West Virginia: Provider of services for persons with intellectual and developmental disabilities (I/DD)
- Disability Rights of West Virginia: Advocates for West Virginia residents with disabilities
- Easterseals: Outreach and advocacy organization for persons with autism and other disabilities
- Ryan White Foundation: Advocates and provides resources for persons with HIV/AIDS
- West Virginia Deaf Commission: Advocates for persons who are deaf or hard of hearing
- West Virginia Developmental Disabilities Council: Advocates for persons with I/DD

Our parent company, CVS Health, has been a supportive collaborator with both the American Lung Association and American Cancer Society through in-store fundraising campaigns. These efforts raise awareness and funds to support cancer research, patient services, and prevention awareness, including tobacco control. In 2019, CVS Health announced a partnership with the Alzheimer's Association, aimed at fighting Alzheimer's disease.

Aetna meets regularly with advocates and stakeholders across West Virginia, including government agencies such as West Virginia's Department of Education and school systems across the State. We work with school-based health centers (SBHCs) to stress the importance of preventive measures such as wellness exams, immunizations, and flu shots. Aetna encourages our enrollees to take advantage of the services offered by the SBHCs. We have and will continue to make presentations at Title I school parent meetings and parent-teacher organization meetings around the state. Those presentations are on a variety of wellness topics. In addition to school initiatives, our Community Engagement team collaborates with the following organizations:

- Family Resource Network
- Parent-teacher organizations within Title I schools
- TEAM for West Virginia Children
- West Virginia ACES Coalition
- West Virginia Alliance for Creative Health Solutions
- West Virginia for Affordable Health Care
- West Virginia Child Advocacy Network
- West Virginia Department of Education and school systems throughout the state

- West Virginia Family Health
- West Virginia Healthy Kids Partnership
- West Virginia Oral Health Coalition
- West Virginia Perinatal Partnership
- Women, Infant, and Children Program

"We, the West Virginia ACES Coalition, value our partnership with Aetna. You, along with your colleagues, have played a key role in establishing and growing the work of our coalition. Active participation and support over the past three years have proved invaluable … Aetna serves as a role model partner, and we look forward to their continued leadership in the health care arena for the betterment of all West Virginians."

—Tricia C. Kingery, Coordinator
West Virginia ACES Coalition

Engagement with Community Services

Our community engagement is not limited to Aetna enrollees, as we work in concert with the State and CBOs to improve all West Virginians' health and wellness. Community services can respond to basic needs, resources, and informal supports that families with young children and adults with disabilities need in concert with formal medical and behavioral health services. We are a member of the West Virginia ACES Coalition and a co-sponsor in bringing the Connections Matter initiative to West Virginia. Aetna's Behavioral Health Medical Director Dr. Frank Angotti and Mr. Smallridge have participated since its inception. Connections Matter is a research-based community initiative that explores how the connections we make in life profoundly impact our brain's ability to grow and our own individual abilities to cope and thrive. . We also sponsored the first training by the West Virginia Primary Care Association for school-based health workers regarding Adverse Childhood Experiences (ACEs).

Engagements to Advance Oral Health

Aetna will continue to engage oral health and disabilities stakeholders, including the West Virginia Oral Health Coalition, the West Virginia Healthy Kids Partnership, and others. Community Engagement staff attends meetings and provides community education on oral health issues. In 2019, we distributed more than 10,000 toothbrushes across the state via

community events, school visits, and resource events. We advocate for improved access to oral health care through school systems

Schools Engagement to Advance Supportive Services for Children

Aetna works closely with **all school systems** across West Virginia, specifically targeting schools with higher populations of Medicaid beneficiaries, such as Title 1 schools. We educate students, teachers, and parents on various health care topics, such as healthy eating and the importance of wellness exams and flu shots. Aetna works with SBHCs to provide screenings and wellness education during this school-wide events.

> *"Here at Buckhannon-Upshur High School (B-UHS), within our physical education classes we have been able to implement the use of pedometers into our various fitness and exercise units. These pedometers generously donated by Aetna have allowed for both our students and physical education teachers to track growth through these innovative exercise tools. We here at B-UHS could not be more appreciative to Aetna for donating these tools to use with our students."*
>
> **—Michael Gitzen, Physical Education Teacher**
> **Buckhannon-Upshur High School**

We also collaborate with West Virginia Head Start programs throughout the state to engage parents by connecting them with comprehensive and essential services that promote health, wellness, and education. We participate in parent and staff meetings where we distribute and discuss easy-to-understand wellness information, topics include the importance of wellness exams, healthy eating, and healthy activities/behaviors.

Through Aetna's outreach to Department of Education representatives, we understand that teachers and school health personnel often do not participate on medical care teams, which often leaves them frustrated. Our model of care is sensitive to teachers' and administrators' needs by providing tools and resources to effectively address behavioral health needs and to aid them in better managing challenging behaviors.

Creating Collaborations in Behavioral Health: According to the National Technical Assistance Network for Children's Behavioral Health, one in five children will experience a mental health disorder, and one in ten will experience a behavioral health issue that is so significant it impacts the child's ability to function socially, academically, and emotionally. To address behavioral health issues and trauma caused by ACEs in children enrolled through TANF and WVCHIP eligibility, we are collaborating with Cabin Creek Health Systems and the Marshall Health Center for Rural Health to develop an evidence-based, integrated, intensive coordination of care approach that targets high-risk children, including WVCHIP enrollees attending middle/high schools in Kanawha County, to improve health outcomes.

Aetna and CVS Health have made a significant commitment, leading our social responsibility by being the first in the nation in removing all tobacco products from our retail stores and focusing on national interventions to eliminate and reduce the use of tobacco in all ages, but especially for children and teenagers. To that end, we have partnered with Stanford University to develop the Tobacco Prevention Toolkit, which aims at preventing middle and high school students' use of cigarettes, cigars/cigarillos, chew, hookah, and electronic cigarettes. The program is deployed at schools, and Aetna is committed to implement this program in many of our West Virginia schools. **Aetna is also developing a question around vaping on the Health Risk Questionnaire**. If the respondent answers yes to participating in vaping, the individual will be transferred to the Care Management department for education.

Engagement to Address Neonatal Abstinence Syndrome

An example of a successful collaboration is with the West Virginia Perinatal Partnership, whose goal is to improve the health outcomes of pregnant West Virginian women and their babies.

West Virginia Perinatal Partnership (WVPP) enrollee outcomes have included full-term healthy babies, a family preserved, sobriety, further education, and employment. To support the WVPP in their efforts, Aetna provided them a $10,000 grant to help develop an educational program for health care providers focused on breastfeeding mothers with a history of opioid abuse or who are receiving medication-assisted treatment (MAT).

Lily's Place Achieves Positive Outcomes

Aetna supports pregnant women with TANF and other eligibility at risk of delivering babies with neonatal abstinence syndrome (NAS) by co-locating a nurse care coordinator at Lily's Place, the first NAS center in the United States. Lily's Place is a one-of-a-kind provider for babies with NAS and Aetna was the first MCO to contract with them.

Our embedded Aetna care coordinator meets with the mothers face-to-face, enrolls them in care management, and follows them throughout their pregnancy and concurrent treatment for substance use disorder (SUD).

Following birth, the baby is enrolled in care management and followed through the first year. The program has shown success in keeping the mother engaged in prenatal care as well as engaged in SUD treatment. Most importantly, most babies remain with their birth mother.

In 2018, through the NAS program, 59% of mothers remained in opioid treatment and/or counseling during pregnancy and through their first year after delivery. By the second quarter of 2019, this number increased to 88%.

Approach to Establishing and Maintaining Relationships with Provider and Medical Associations

CS002	The Vendor should describe its approach to establishing and maintaining relationships with applicable provider and medical associations.

Through our Community Engagement team, we have worked hard to establish and maintain effective, collaborative relationships with numerous provider and medical associations. We outreach to organizations around the state, including those listed below, for services for children and persons of all ages with **dedicated, focused, and tailored data-driven, evidence-based solutions to best meet their unique and complex health needs:**

- Behavioral Health Provider Association
- Charleston Area Medical Center Clinically Integrated Network
- Healthy Kids Coalition
- Marshall University
- National Association of Social Workers – West Virginia Chapter
- Provider Response Organization for Addiction and Care Treatment (PROACT)
- School Based Health Assembly
- West Virginia Board of Medicine
- West Virginia Healthcare Association
- West Virginia Hospital Association
- West Virginia Nurses Association
- West Virginia Oral Health Coalition
- West Virginia Osteopathic Medical Association
- West Virginia Partners in Health
- West Virginia Primary Care Association
  - Community health centers (CHCs)
  - FQHCs
- West Virginia Rural Health Association
- West Virginia State Medical Association
- West Virginia University Health Systems

Engaging and Maintaining Provider Association Relationships

To improve overall population health, we believe sustained engagement and collaborative relationships with provider associations is important.

> *"Great Rivers Regional System for Addiction Care seeks to begin comprehensive programs 'in' and 'with' local communities and harness the expertise of multiple partners, including health care providers, public health experts, first responders, and community-based organizations. We have the privilege of Aetna being an active participant on our advisory board. They have been a strong partner since our inception and support the four counties … in multiple ways, including financial support to develop PROACT. It brings together addiction and recovery services, primary care, social services, and spiritual care all under one roof. Aetna is dedicated to the community and the overall wellness of all individuals."*
>
> **—Tina Ramirez, Executive Director, Great Rivers Regional System for Addiction Care**

Aetna has a longstanding collaboration with PROACT as they strive to effectively serve, educate, and treat every individual through and beyond the initial stages of recovery until they become long-term, committed members of society. PROACT, located in Huntington, provides both referrals and complete assessment, education, intervention, and treatment solutions in a single accessible service hub by combining behavioral, social, and medical resources from the community to effectively triage enrollees with addiction. Aetna saw that PROACT would be an effective collaborator against opioid addiction and provided a $400,000 grant to PROACT as shown in **Figure 6.4.1-2**. PROACT offers a variety of treatment avenues, including MAT and abstinence-based services. PROACT treatment begins with a clinician conducting a comprehensive, structured clinical assessment to inform a diagnosis and recommended care plan for social or personal needs requiring further referral. Individuals



Figure 6.4.1-2: Aetna's Support for PROACT
Aetna collaborates with PROACT for addiction recovery.

entering PROACT services receive timely access to a physician as well as to all other services offered by our program.

Aetna is a founding member of Great Rivers Regional System for Addiction Care (Great Rivers), the innovative prevention and treatment program of which focuses on addiction and recovery efforts, seeking a measurable impact in saving lives and changing the course for individuals, children, and families impacted by substance use disorder.

In part due to the opioid epidemic, many grandparents in West Virginia raise their grandchildren while their adult children are unable to care for their own children due to being in recovery, in prison, or deceased. We provided the West Virginia Healthy Grand Families organization with a $15,000 grant in 2019 and provide grandparents health care education to help care for the children. Grandparents in the program participate in an eight-week training program to help them manage health care access, medications, and other supports for their grandchildren.

Efforts to address the Opioid Epidemic and Substance Use Disorders

Our Community Engagement team collaborates efforts with all Aetna departments, including Care Management, and joins forces with CBOs to make certain we understand the unique health care challenges West Virginians face so we can act as catalysts to make progress regionally. This approach leverages regional and community-based supports coupled with a thorough understanding of the health challenges West Virginians face.

National Success Addressing Opioid Crisis
Between July 2016 and October 2018, the Aetna Medicaid organization increased the rate of non-opioid treatment for chronic pain by 52.9% and decreased the rate of opioid prescriptions for members with opioid use disorder by 44%.

Aetna works in conjunction with Cabin Creek Health Systems and Marshall Health SBHCs to provide coordination of care and integration of behavioral health services through a patient-centered

health delivery approach. The system incorporates children, families, and/or other supports into a system of care team, and all care delivered utilizes a trauma-informed care approach.

Approaching and Establishing Relationships with Professional Boards

CS003	The Vendor should describe its approach to establishing and maintaining relationships with applicable professional boards.

Engagement with these professional boards assists us in gaining insights and engaging with expertise in services for children and persons of all ages **with dedicated, focused, and tailored data-driven, evidence-based solutions to best meet their unique and complex health needs**. This collaboration includes outreach, education, and training to remove barriers to care coordination and improved service for Medicaid enrollees, including those children enrolled in WVCHIP. Our relationships include the following:

- American Academy of Pediatrics (WV)
- Board of Nursing
- Professional licensing boards
- Social Worker Association
- Rural Health Collaborative
- West Virginia Board of Osteopathic Medicine
- West Virginia Health Care Association
- West Virginia Medical Professional Health Program
- West Virginia Pediatric Society
- West Virginia Primary Care Association
- West Virginia State Medical Association

To illustrate our engagement with professional boards, in 2019 Aetna was a sponsor of several conferences, including the West Virginia State Medical Association Healthcare Summit, West Virginia Medicaid Summit, and West Virginia Association of School Nurse's Conference. Aetna has also reached out to both the Boards of Medicine and Osteopathic Medicine to obtain up-to-date lists of those providers licensed in the state to increase network capacity to improve access to specialty care. We sponsor an annual event with the West Virginia Social Worker Association's annual meeting and we have also attended the West Virginia Regional Health Summit. Our Medical Directors are involved with boards. Dr. Adam Breinig, is a past president of the West Virginia Academy of Family Physicians and is currently a participating member. Dr.

Gibbon is a member of the West Virginia Health Information Network Clinical Committee. We sponsored, attended, and/or presented at many conferences and events over several years with professional boards, including the following:

- American Academy of Pediatrics Conference
- Healthcare Facility Management Association
- Perinatal Partnership Conference
- West Virginia Behavioral Healthcare Providers Association
- West Virginia Medical Office Managers Association
- West Virginia State Medical Association

We intentionally engage professional boards that focus on populations served within this contract to make certain we engage providers across the care spectrum. We actively seek continual professional board engagement to maintain effective relationships and stay on the forefront of innovative care solutions for our enrollees.

Coordinating Agencies to Provide Complimentary Services to Members

CS004	The Vendor should describe its process to coordinate with agencies providing complimentary services to the member.

Aetna has been joining forces with local organizations for over 23 years to address housing affordability and instability, food security, employment, and other barriers. Community and complimentary services can respond to basic needs, resources, and informal supports by creating connections to community resources that families need.

Relationships with Complimentary Service Providers

We coordinate with community agencies and resources and complimentary service providers to engage enrollees in comprehensive care solutions as we fully engage enrollees in their greater community. Through FRNs, we engage in and help provide resources and support, including health care, homeless services, food and nutrition, and education. Community agencies and complimentary providers that we routinely engage include the following:

- 4-H
- ABLE Families
- Adolescent Health Initiative
- Alliance for Creative Health Solutions

- American Cancer Society
- American Lung Association
- Big Creek People in Action
- Camp Appalachia
- Catholic Charities
- Children's Safety Network
- Circle of Parents Support Group
- City/county housing authorities
- Clinical Committee for the WV Health Information System
- Coalition to End Homelessness
- Community Crossings
- Coordinating Council for Independent Living
- County Boards of Education
- County Child Protective Services offices
- County health departments
- Covenant House
- Diabetes Coalition
- Eastern Panhandle Empowerment Center
- Eastern WV Community Action Agency
- Facing Hunger Food Bank
- Family Information Support and Health
- Gabriel Project
- Goodwill Industries
- Great Rivers Regional System for Addiction Care
- HAPI Project
- Hardy County Child Care Center
- Head Start
- Heart of Appalachia
- Help Me Grow West Virginia
- Homeless shelters
- Hunger Free West Virginia
- Intermountain Collaborative
- Jacob's Well
- Just for Kids
- Juvenile justice agencies
- KIDS COUNT
- Lily's Place
- Local food pantries and feeding programs
- March of Dimes
- Marcum Terrace Family Resource Center
- Maternal and Child Health Committee
- Mountain Heart
- Mountain State Educational Services Cooperative
- Mountaineer Food Bank
- Mountains of Hope
- New River Health Association
- Newborn Hearing Screening Advisory Committee
- One Voice
- Our Babies: Safe and Sound
- Parent Educator Resource Center
- Parents as Teachers
- Perinatal Partnership Substance Use in Pregnancy Committee
- Practice Based Research Network
- PRIDE of Logan
- Project Launch
- Raleigh County Community Action
- Reconnecting McDowell
- Right from the Start
- Safe at Home
- Salvation Army
- Starting Points
- Success by 6
- TEAM for West Virginia
- The Arc of Mid-Ohio Valley
- The Shack
- Think Kids
- Union Mission
- United Way/Central West Virginia
- United Way/ Southern West Virginia
- United Way of the River Cities
- Faith-based organizations
- West Virginians for Affordable Health Care
- Workforce West Virginia
- West Virginia ACES Coalition
- West Virginia Child Advocacy Network
- West Virginia Department of Veteran's Assistance
- West Virginia Family Health
- West Virginia Family Resource Network
- West Virginia Healthy Grand Families
- West Virginia Healthy Kids Partnership
- West Virginia Job Corps
- West Virginia Library Commission
- WV National Guard Family Programs

- West Virginia Office of Community and Rural Health Services
- West Virginia Office of Community Health Systems and Health Promotion
- West Virginia Office of Emergency Medical Services
- West Virginia Office of Nutrition Services
- West Virginia Oral Health Coalition
- West Virginia Rural Health Association
- West Virginia Statewide Afterschool Network
- West Virginians for Affordable Healthcare
- West Virginia University Extension
- YMCAs across West Virginia
- Youth Services System, Inc.

We are a company that focuses on **wellness and preventive health opportunities** for our enrollees. We act as a resource, listening and engaging in solutions for enrollees. For example, our targeted outreach identified child wellness exam scores in Doddridge County were well below the state average in our effort to address health disparities and gaps in care, so we took action attending a mobile food pantry event in the county, at which we provided health information on the value of wellness exams and childhood immunizations. Aetna will continue to approach all stakeholders with the **same respect and spirit of engagement** as we do with each enrollee. We learn from those who have divergent perspectives on the concerns at hand, and as such, these varied perspectives and areas of expertise will educate a robust and effective leadership, advocacy, and governance infrastructure.

> *"The FRN is a 501c3 agency that supports families and communities by working on issues identified as priorities for their community. Aetna has been a great source of charitable support for us. They have provided our organization with donations and generous sponsorships for several years to support our community baby showers. Raleigh County's baby showers have helped over 200 women and babies in our area. Aetna's contribution has been critical to this success. The FRN has also collaborated with Aetna to bring a food giveaway to our area distributed by Mountaineer Food Bank. Many families received much-needed food items. Again, Aetna's contribution made a huge impact on the success of this event. Their support helps us to maximize our funding sources so that we may carry out our mission of helping those in need. We look forward to many more years of partnering with this organization."*
>
> **—Deborah Williams**
> **Director, Raleigh County Community Council/FRN**

Our Approach and Methodologies to Community/Stakeholder Engagement

West Virginians put stock in the power of community. Engagement starts with enrollees and families becoming active in their communities, and then eventually moving into leadership positions to better assist and give back to their neighbors. Aetna is actively engaged with West Virginia's 47 FRNs positioning us to support quality outcomes at the individual, community, and regional levels. This comprehensive approach makes sure that we sustain quality outcomes over time as relationships take hold and deepen between our enrollees, neighbors, and Aetna employees.

> *Aetna has been and continues to be a partner to the Ohio County Family Resource Network through their attendance at General Network meetings six times a year, monthly Family Ways Community Collaborative meetings, and as exhibitors at local resource fairs. They are also generous with hygiene items and information sharing."*
>
> **— Claudia Raymer, Executive Director, Ohio County Family Resource Network**

We engage with FRNs in programs addressing food insecurity by implementing a weekend food backpack program, a community garden, and/or food drives. We also collaborate with FRN stakeholders to solve urgent problems and work on approaches such as community development, early childhood programs, child abuse prevention, and economic and resource development.

> *"The Marcum Terrace Family Resource Center in Huntington has had a relationship with Aetna Better Health of West Virginia for several years—and it continuously grows and expands. Aetna has sponsored the monthly food pantry at the FRC for over six years. Their contributions provide food boxes for approximately 80 families each month, supplying food for after-school programs and emergency food boxes. Aetna has a member of their team present each month to assist with the food ... and give helpful health care information.*
>
> *Aetna can always be counted on to support the events and activities of the FRC. They truly understand the importance of collaboration. They are a vital part of our community."*
>
> **—Shane Randolph, Coordinator Marcum Terrace FRC**

Aetna has worked with TEAM for West Virginia Children on multiple efforts, and we were the first MCO in West Virginia to pair with TEAM's *Our Babies: Safe and Sound* campaign, which focuses on promoting infant safe

sleep and preventing shaken baby syndrome. Over 20 care managers participated in an onsite training in February 2018 and the *Let's Talk About Safe Sleep* statewide meeting. Aetna supported over 500 families with safe sleep education and almost 400 families with portable cribs so that infants had safe places to sleep.

Collaborative Efforts to Support SDOH

Aetna has referred members to community resources in West Virginia for more than 23 years, but we have never had the data sharing capacity to show the results of our referral services. In 2020, Aetna will integrate the Unite Us platform in our Case Management, Member Services, and other departments to provide an automated, data-focused solution to community referrals. In addition, Aetna includes our provider network in collaboration with Unite Us to integrate provider referrals to SDOH needs of our members. The Unite Us platform provides the unifying infrastructure between health care entities and community-based organizations. This infrastructure provides the ability to track an individual's wellness journey. Unite Us will have an initial rollout in seven counties located in central and western West Virginia effective March 1, 2020 spanning rural and urban communities.

> *"Expressing my thanks and gratitude to Aetna for attending and contributing input at our local Family Issues Task Force meetings and our regional FRN meetings. Your presence at our annual Celebrate the Family event was greatly appreciated as well. We are looking forward to working with you in our Grant and Hardy County Coalition Building endeavors for the betterment of our community. We hope you will continue to partner with us in our tobacco and drug prevention efforts, Healthy Grandfamilies, foster care services, back-to-school events, baby bank and baby shower events, the Annual Community Christmas Luncheon, Family Fun Day, and numerous other events as they are planned to meet the needs of our area. The partnership with Aetna is valuable to the success of our FRN plans and allows us to implement them in the community. I fully support Aetna and the positive role it plays in foster care and Medicaid health care coverage."*
>
> **— Gina Hinkle**
> **Secretary, Grant and Hardy County Family Issues Task Force**

Aetna recognizes the relationship between health care disparity and food insecurity, especially in West Virginia, which has some of the highest rates of poverty and food insecurity across the nation. Poor nutrition impacts brain development and growth to render West Virginia children and pregnant women and their unborn children at a major disadvantage, therefore, we collaborate with the Perinatal Partnership, a program with the goal of improving health outcomes for pregnant women and their babies. Aetna has a longstanding relationship with Facing Hunger and Mountaineer Food Banks, both of which work with local feeding programs to reach children who rely on the National School Breakfast and Lunch programs and Backpack program.

In February 2018, there was a prolonged teacher's strike, and the school feeding programs were sharply reduced or completely halted. Aetna donated $3,000 to Facing Hunger Food Bank and $10,000 to Mountaineer Food Bank to help make sure students facing food insecurity maintain quality food access during school closures. We understand that more than **40 of West Virginia's 55 counties are considered food deserts.** Therefore, we have become involved with the Mountaineer Food Bank as it is a vital resource for struggling families. **Figure 6.4.1-3** shows our Aetna team volunteering at a mobile pantry event in Monongalia County, which we sponsored with the Mountaineer Food Bank. Aetna purchased a truck for Mountaineer Food Bank to help with their mobile food pantry events. In addition to supplying funding and volunteers that make the distribution of healthy food possible, we provide health care information and personal care items. **Since 2018, Aetna has sponsored the distribution of nearly 70,000 pounds of food.**



Figure 6.4.1-3: Mountaineer Food Bank Mobile Food Pantry
Aetna volunteers organize food items to distribute.

Aetna also works with faith-based organizations such as **One Voice, a nonprofit public charity that helps families and communities suffering from substance abuse.** They have been instrumental in bringing communities together to educate, train, and mentor individuals and stakeholders through community forums with support from the governor, U.S. and state senators and representatives, and the attorney general.

> *"The partnership we have with Aetna is very special to us. For a very long time, we partnered together to improve the lives of those receiving assistance through the Family Resource Center at Marcum Terrace in Huntington. As that relationship developed, we have had many occasions to have Aetna staff, with the great support of Jim Smallridge and Todd White, volunteer at mobile pantries, as well as to spend time here at the food bank—either in a group or individually—to simply work shoulder-to-shoulder with our team to aggregate food to provide to those that we collectively serve. Aetna truly 'shows up' to provide better health and well-being to those they serve, and that we serve along with them. We are grateful for their partnership and look forward to our continuing work together."*
>
> **—Cynthia Kirkhart, Executive Director**
> **Facing Hunger Food Bank**

We are also **active in supporting housing and other initiatives that address community health disparities and lack of supports** with the following entities:

- Various city and county housing authorities, such as the Housing Authority of Mingo County and Housing Authority of Wayne County **to increase access to affordable housing**
- West Virginia Library Commission and numerous local libraries to increase Internet access and to provide outreach and prevention forums
- West Virginians for Affordable Healthcare's Medicaid Matters group; we are also a sponsor of their Medicaid Summit
- West Virginia Healthy Kids Partnership to address health disparities and improve health outcomes
- Family Information Support and Health (FISH) program, which provides education to families about common mental health conditions that affect children, including ACEs. Our behavioral health medical officer provides training in concert with our training collaborative, which designs and delivers training models for each local service delivery area.

Through our Member Advisory Committee (MAC), we listen and engage in rural, urban, and community issues, listening to enrollees across West Virginia. Through the MAC we will continue to learn enrollee access concerns to transportation issues and use insights to

collaborate community stakeholders to create innovative solutions in the regions that do not have transportation resources in place.

To best address this issue, Aetna is working closely with Susan Gamble, Ed.D., director of the West Virginia Statewide Afterschool Network. Dr. Gamble will be instrumental in designing a creative response to the transportation needs for children attending much-needed after-school programs, as she has access to the numerous informal community individuals, faith-based organizations, and nonprofit agencies that have graciously stepped up to meet this community need. Aetna's Medical Management team has engaged LogistiCare, the state's medical transportation vendor, to speak to staff concerning transportation programs to aid enrollees. To address SDOH needs, an Aetna care coordinator facilitated a solution with LogistiCare for transporting a six-year-old living in the eastern panhandle who was recently diagnosed with cerebral palsy. According to the West Virginia Health Care Authority's "West Virginia State Health Plan," rural transportation is a burden particularly in West Virginia, where 64 percent of the population lives in rural areas and one of the highest rates of communities with a population of less than 2,500 persons, creating scalability difficulty for transportation providers. Aetna will continue efforts in facilitating a problem-resolution process for transportation needs.

Throughout our West Virginia experience, Aetna has joined local organizations to address housing affordability and instability, food security, employment, and more because these are direct contributors to improving SDOH for children and families.

CVS Health Workforce Initiatives (CHWI) provides Aetna with access to existing CVS partnerships to empower our enrollees to obtain the skills needed to build career-focused employment. The initiatives offer hands-on training programs and will add value to our

collaboration with Workforce West Virginia in helping individuals looking for meaningful employment as pharmacy technicians and retail associates. Our CVS Health National Apprenticeship, in partnership with West Virginia Workforce Boards, includes classroom and on-the-job training with four U.S. Department of Labor registered apprenticeships for pharmacy. The Charleston West Virginia Job Corps provides tuition-free pharmacy technician training at the Job Corps center for young people aged 16-24. CHWI also partners with a West Virginia Junior College by providing pharmacy technician externships at local CVS pharmacies. **Since 2015, CVS Health has hired 1,739 new West Virginia employees; 486 were eligible for a Work Opportunity Tax Credit, including 146 eligible for public assistance** such as food stamps, TANF, Veteran Supplemental Nutrition Assistance Program, and SSI..

Initial and Ongoing Training to Community Stakeholders

We offer Aetna training to stakeholders so that **together we embark on continuous learning.** Training is a key element of our engagement efforts, as we believe each person and every community organization is a lifelong learner. Aetna also understands that adults learn and retain information best through a multifaceted approach, including presentations, experiential, in-vivo demonstrations, and in-the-field coaching, among other modalities.

Aetna's Integrated System of Care Model

Aetna's system of care approach relies on active listening and engagement with community stakeholders. These interactions give insight to the needs of individuals as well as on a population health level to better address specific community needs. We learn what keeps CBO directors up at night and the connections needed to make a real difference in people's lives and their communities. This is how we address community health disparities like the high prevalence of asthma, diabetes, and obesity in West Virginia as compared to other states.

Aetna's integrated system of care model is community-connected to improve delivery system capability. The model includes a full spectrum of community-based physical, behavioral, and oral health care treatment services, along with psychosocial services and supports, to create tailored, holistic care approaches that achieve the following:

- Drives collaboration across agencies and community-based organizations
- Addresses cultural and linguistic needs, such as language and cultural differences that create barriers for adults with limited English proficiency. Our model considers enrollees with visual and hearing impairments/disabilities, need for American Sign Language, Braille, etc.
- Recognizes and honors enrollee voice and choice
- Acknowledges trauma's impact on enrollees and families and exacerbations of experiences in adulthood, therefore seeking innovative solutions to reduce quality of life impacts

Coordination with each stakeholder group requires different approaches based on perspectives, regulatory constraints, funding, and direct experience. A 'one size fits all' approach does not work when it comes to systemwide reforms and innovation. Our most important stakeholders are our enrollees. We engage the community to surround enrollees with effective supports and resources. We ensure enrollees get access to medical care and social needs by leveraging the expertise and leadership from CBOs across the state to ensure West Virginia enrollees have **voice, choice, and preference** in each step through their experience with us.

Community Presence Achieves Results

Because of our continual presence engaging West Virginia communities, our regional Care Connection teams provide highly effective services because they live in and know the communities in which they work. The impact of our local approach to care is demonstrated by the following outcomes:

- Increased face-to-face visits: 300%
- Decreased opt-out rate: 41%
- Reduced readmissions: 14%
- Reduced emergency room visits: 7%

5. Member Services

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Member Services (MS) as part of their bid. The Vendor's narrative response should not exceed 100 pages.

Aetna has over 23 years of proven, local West Virginia experience in delivering customized, quality-driven care supported by timely, accurate new member enrollment processes; promotion of member rights; comprehensive, integrated, evidence-based assessment methods; culturally competent staff and programs; targeted, community-level health education programs that promote meaningful member health outcomes; and a 24/7/365 Member Services (MS) call center that offers readily-accessible, service excellence. Our experience, programs, people, and outcomes support the State's goals for enhanced coordination of care, improved communication across stakeholders, reduced fragmentation, and seamless continuity of care, offering West Virginia Mountain Health Trust (MHT), West Virginia Health Bridge (WVHB), and West Virginia Children's Health Insurance Program (WVCHIP) members the opportunity to participate in their health and wellness journey in a meaningful way that enhances quality of life.

At Aetna, we operate with a **Common Purpose** in mind, which means that we advocate for our members' best health by helping them get the most from their benefits, building trust, and always providing a clear path to care. Our Common Purpose is our guiding light – it reminds us why we come to work every day and it means that we engage our employees around a shared commitment to our members. We see what is possible and we work toward that common goal—**we are member obsessed.** It means we transform our thinking, inspire employees to create an optimal member experience, collaborate with others, and activate our promises to deliver supportive, effective care and services. **In West Virginia, we stand shoulder-to-shoulder with**

our members—we act on their behalf as their voice, taking their side, putting ourselves in their shoes, and empathizing with their situation.

Member Services Staff and Community Involvement

Maria Flowers, a Member Services representative, is a native West Virginian who has been employed on Aetna's Member Services hotline for several years. Maria has attended multiple local community events that support and connect West Virginia families to critical preventive, health care services. In collaboration with Aetna's Quality Management department and Valley Health, Maria volunteered as a guide and educational resource for Aetna's diabetic eye exam and well-child health care event. The event offered families and children an opportunity to learn about Aetna resources for diabetes health education and engagement, such as our mobile phone application, and to immediately schedule their well-child visits. Maria told her director, "*The entire day was enjoyable. My last family had five small children who could not talk very well. I discovered that several of the children were deaf. I know some American Sign Language, so I was signing with the kids. The kids taught me more sign language, we were having fun, and smiling a lot. It made me so happy that I could interact with them too.*"

Helping our members get the most from their benefits means asking the unasked questions and taking that extra step when we see an opportunity for a better solution. We developed a job aid for our MS representatives that offers suggestions for how to provide member-obsessed service excellence on different call types. For example, if we enroll a new member, representatives make a new member feel welcome by recognizing the caller as a new member and offering important educational information such as the type of information available in the member handbook or how to download and navigate the smartphone mobile application offering a secure member portal.

Building trust is something we do through action and not just words. It means keeping our promises, meeting our commitments, and being trustworthy. Aetna's Common Purpose results in each member experiencing an individualized, differentiated service experience that is proactive, friendly, and efficient. This seamless continuity provides a clear path to care making it

easy and hassle-free for each member—on each call, in each interaction, and at each touchpoint, written, media, or in-person.

New Member and Member Enrollment

MS003	The Vendor should describe its methodology for assigning members to a Primary Care Provider (PCP) including, but not limited to, claims history, proximity, and within contractually defined timeframe.
MS004	The Vendor should describe how they will develop protocols to notify members of Primary Care Provider (PCP) assignment.
MS005	The Vendor should describe how they will educate members of the right to change Primary Care Providers (PCPs).
MS015	The Vendor should describe how they will distribute and provide notice of member handbooks on an ongoing basis, according to an established turnaround time, and including, but not limited to, the following:
MS016	Updates to the member handbook
MS017	Handbooks requested ad hoc by a member
MS027	The Vendor should describe its new member enrollment and education process, defined as the time of initial notification of the member's enrollment through the first month of actual enrollment, which includes, but is not limited to, the following:
MS028	Member contact, including welcome calls, welcome letters, and/or home visits
MS029	Outreach to members who are difficult to contact, including disabled members and members without telephones
MS030	Processing and issuing identification cards
MS031	Distributing member handbooks
MS033	The Vendor should describe how they will provide a secure member portal that allows members to log in and access benefit information including, but not limited to, the following:
MS034	Medical records
MS035	Authorization status
MS036	Cost sharing information
MS037	Temporary identification (identification) cards
MS038	Confirmation of Primary Care Provider (PCP)
MS039	Provision of access to guardians
MS040	The Vendor should describe its process to inform members that program information is available in paper form without charge upon request and available within five (5) business days.

MS044	The Vendor should describe its policies and procedures related to issuance of member identification cards within contractually defined timeframes.

Aetna extends our **Common Purpose** initiative to members from the point of enrollment through ongoing services by ensuring high-touch, personalized, outreach and education that meets each member's[1] unique needs. Our members not only deserve the best care, but deserve interactions that support their rights, improve continuity of care, and remove barriers to optimal health outcomes. For example, members call us seeking urgent assistance locating a specialty provider. Our MS representatives not only offer immediate support by locating the right provider and assisting the member to schedule an appointment, we take the time to offer step-by-step guidance on navigating our secure member portal or smartphone

"I was born in Charleston, West Virginia and it's been my home all my life. Every day at Aetna is an opportunity to live the Common Purpose of advocating for our members. I enjoy helping others outside of work as well. At an early age of three, I was introduced to dance. My parents felt this would help me overcome my shyness and bring the out the best in me. I now coach cheerleaders at a local middle school, I and I teach dancing to children. I also mentor young girls who have been neglected and abused. In my spare time, I do freelance photography and some of my sports action shots have been featured on the news and in local newspapers. As a Member Services representative, I get to help people every day. Recently, an elderly woman made an appointment to get a mammogram. When the member arrived, she was told they do not accept Medicaid. The member was upset because she had a family history of breast cancer, and she had just lost her sister to breast cancer a few months back. The member was so emotional and scared she was going die of the same thing. I calmed the member down by taking long deep breaths with her to bring down her heart rate. Once the member was calm, I placed several calls to providers I found doing a search of our internal resources. I was able to get the member an appointment that day. With the member's permission, I gave the provider all the member's information including her Medicaid information to make it easier on the member. She thanked me for taking time out to assist her. When the call was over, I reached out to her care manager to inform her of the steps I took for that member."

—Sonya, Member Services Representative
Aetna Better Health of West Virginia

[1] Throughout this RFP, when we use the term "member," we are collectively referring to a definition that is representative of who a member is per the populations we serve and intend to serve including adults and children and the legal custodians of children enrolled in WVHIP (e.g., parents and legal guardians).

mobile application, both which include advanced provider search functions. Our welcome and outreach begins at the time of enrollment. We have extensive experience with new member enrollment and ensuring high-touch, frequent interactions that exceed Department of Health and Human Resources (Department) requirements for outreach and education. Members have support and resources available via multiple communication methods, including translation and oral and American Sign Language (ASL) interpretation services, which allow them to understand the managed care system, navigate services and support, and progress toward optimal health.

[MS027] New Member and Member Enrollment and Education

Once the monthly enrollment roster is received from the Department, Aetna enrolls all new members in the MHT, WVHB, or WVCHIP programs, respectively. Health plan representatives welcome members to our program and conduct initial outreach using telephone and written correspondence according to the frequency and intensity of contact per contractual requirements and as designated in our intensive care management (CM) programs designed for West Virginia members. **[MS027]**

[MS028] Initial Member Contact - Welcome Calls, Welcome Letters, and/or Home Visits

Aetna supports welcome and outreach to the program through automated welcome calls, distribution and explanation of our welcome packet, member identification (ID) card, and education about member rights, grievances and appeals (G&A), enabling services, primary care provider (PCP) assignment and reconciliation. Initial contact for members occurs within one day of receiving the monthly enrollment file via our automated outbound call management and tracking system. This automated process welcomes new members to the Aetna health plan and asks members to complete the required health risk questionnaire (HRQ) using prompts on their telephone keypad. **[MS028]** If members have a working smartphone, they receive a welcome

text that reads, "Hi, it's Aetna Better Health! As a member, you can get messages with important info about your health and benefits," and they receive contact information about how to enroll in our Aetna Health text messaging plan. **[MS028]**

Aetna mails each member an ID card with information about the member's PCP. **[MS028]** We also mail a welcome packet and customized materials to meet the unique needs of West Virginia members by providing the following required items, and other printed materials deemed appropriate for the region or population served:

- A welcome kit and welcome letter
- A member notice of privacy practices outlining member rights to privacy
- A notification advising members how to request a member handbook, including written taglines in large print for prevalent languages and oral and ASL interpretation services **[MS043]**
- A letter outlining the West Virginia workforce initiative
- Contact information for the West Virginia enrollment broker
- Education on the importance of the WVCHIP PCP selection including waived co-payment for choosing a Patient Centered Medical Home (PCMH) provider
- Information on how to use different levels of service

Aetna tracks all new member welcome outreach contact, ensuring adherence to Department requirements and in alignment with the **National Committee for Quality Assurance (NCQA) standards**. We complete additional outreach via automated or live calls for all unsuccessful attempts. We track all contact attempts, whether through our automated outbound call management and tracking system or via text campaign. Our automated outbound call includes three attempts across two days, calling at varied times of the day to maximize contact. If we reach a non-designated member, a voice recording, or a busy signal, we make additional attempts across three more days. Designated staff complete a review of contact attempts and search in our system for updated demographic information, in

effort to make another attempt at contact, when necessary. If MS or CM staff identify new demographic information during initial and ongoing contact, we place a note in the member record and warm transfer callers to the Department, ensuring demographic updates are properly recorded. Demographic information entered into the Aetna system overrides other contact information, ensuring the most recent, working smartphone and/or address populates to the member's record. We report all members we have been unable to contact and the nature and disposition of those attempts within the first 30 days of enrollment to the Department in adherence with the Department's specific requirements and timeframes. **[MS027]**

We understand our members may experience transitional housing or instability in permanent housing. We support our members, especially members with special healthcare needs, by accepting addresses for shelters, temporary places of residence, and other non-traditional places of residence.

[MS029] Member Outreach for Members who are Difficult to Contact

If we are not able to reach members during our initial automated outreach, we conduct live, telephonic outbound calls. If a member does not have a telephone, we conduct in-person visits as part of our outreach attempts. All attempts are completed, documented, and tracked in alignment with State and **NCQA standards.** For our members enrolled in care management (CM) programs, CM staff complete initial live, outbound calls to members within five business days of enrollment in a CM program. If there is no contact, care managers complete a second live, outbound call attempt at a different time of day within three business days. If there is still no response after the second attempt, care managers issue a written letter on the same day of the second unsuccessful attempt that is mailed to the member's address. The letter explains the reason for the contact and includes how to contact us. **[MS029]** If a member is being prescribed

medications and we have knowledge of this at the time of enrollment, our CM staff reach out to the prescribing pharmacy to inquire if the member will be picking up medications and ask the pharmacy staff to call our department when they are onsite. Once we make contact, when applicable, we offer our members a **no-cost, Lifeline smartphone**, which offers members without telephones the ability to contact our MS and CM departments, the Department, providers, and community-based organizations (CBOs).

Aetna's national Medicaid organization has initiated innovative approaches with CVS and in partnership with the Department, we will leverage this expertise in West Virginia to improve member engagement for difficult-to-reach members. Aetna CM staff can access retail pharmacy contact information for our members through our **Engagement Dashboard.** By integrating functional areas, we can increase member engagement opportunities with members who are CVS retail pharmacy customers. This integration supports our ability to outreach difficult-to-reach members or members who may benefit from CM services. Our engagement dashboard provides member contact data from CVS retail pharmacies for Aetna CM staff to increase our reach rate for previously difficult-to-reach members. If CM staff successfully reaches a member, the contact information is added to our electronic CM system for future use. Additionally, we are evaluating opportunities for **in-store engagement conversations,** which would support the Department's goal for enhancing access to care and can improve our reach rate for difficult-to-reach members. In-store engagement conversations

CVS offers 57 retail stores statewide in West Virginia, with almost all locations accepting Supplemental Nutrition Assistance Program federal benefits and 46 locations accepting Women, Infants, and Children federal benefits for pregnant and breastfeeding women and children under the age of five. Nearly 46 percent of Medicaid members live within five miles of our CVS retail locations.

are a CVS retail pharmacy collaboration in which Aetna places a digital alert in the CVS system to alert the CVS Pharmacy staff that we are looking to engage a difficult-to-reach member. We improve engagement in CM by leveraging CVS Pharmacy in-person interactions and providing a physical takeaway card to educate members on Aetna CM programs. The CVS Pharmacy staff documents interaction notes and the best day/time for the person to be reached, which is sent back to the Aetna clinical documentation system. Clinical staff in the Care Connections department can use this information to complete outreach. Both CVS opportunities, in-store engagement conversations and the Engagement Dashboard, increase our opportunity for clinical engagement and outreach to members. **[MS029]**

We support and promote regulations and requirements that support the availability of auxiliary aids and alternate methods of communication for our members with disabilities. Aetna health plan staff are fully trained on utilizing text telephone (TTY)/telecommunication device for the deaf (TDD), ensuring communication about new member enrollment or CM programs. Our new member written materials are offered in Braille and in other languages or font size upon request. Aetna health plan staff are fully trained on member rights, including ensuring member materials such as the member handbook or treatment plans are provided in Braille upon a member's request. **[MS041]**

[MS030] Processing and Issuing Member Identification Cards

Aetna's Enrollment department is responsible for facilitating the provision of timely member ID cards within the timelines referenced in the Model Purchase of Service Provider Agreement for State Fiscal Year 2020. A card is provided for every West Virginia member. The member ID card includes the West Virginia program name and logo, the member's ID number,

Our average turn-around time for issuing member identification cards in 2019 was 3.6 days.

the name of the member's PCP, the PCP phone number, and phone numbers for Aetna MS and the Crisis hotlines.

Aetna has a **strong history of exceeding enrollment turnaround time goals for member receipt of the card.** We issue ID cards earlier than the required timeframe of within five business days of receipt of the daily enrollment file containing the member's information. **[MS044]** Member ID card images are available upon enrollment on our secured mobile application and in our secured portal. Aetna will offer a **separate member ID card for our WVCHIP members**, ensuring accurate and easy-to-find membership in the WVCHIP program. When members call the MS department, they will hear and select the prompt in the integrated voice recording for WVCHIP. Once selected, MS representatives are notified the call is from a WVCHIP member and will access WVCHIP resources to handle the call, including information about WVCHIP providers and waived co-payments for members who enroll in a PCMH. **Figure 6.5.1-1** illustrates West Virginia member ID card as viewed front and back. Aetna will seek approval from the Department as necessary for a separate WVCHIP ID card.



Figure 6.5.1-1 Aetna Member ID Card
Aetna's member ID card offers critical member and Aetna contact information in a convenient, easy-to-read manner.

Members can request a new ID card using the self-service functions embedded in our integrated voice recording automated messaging when they call the MS hotline. Members select the appropriate option and can obtain the information from our operating system. MS representatives can validate a member's address and reconcile the demographic information via

a warm transfer to the appropriate state agency. MS representatives educate and inform members of the **multiple ways to secure the information** on a West Virginia member ID card, including the following:

- **Accessing a member ID card via our member portal**
- **Viewing and using the member ID card via Aetna's mobile app**

Our MS representatives help reissue new cards 24/7/365, and we reissue an ID card within five days of the request for the following reasons:

- The member reports a lost card
- The member has a name change
- The member requests a new PCP
- Any other reason that results in a change to the information disclosed on the member's ID card

West Virginia Aetna staff verbally communicate or send a facsimile to a primary care or specialty provider as needed for members without telephones. When a member attends a medical, behavioral health (BH), dental, or vision appointment, providers can access eligibility and benefits information including the member's ID card via the secure web portal. Members can access their member ID card at any time or during provider visits via our smartphone mobile application, as depicted in the figure above. MS representatives take every opportunity to offer tutorials, educating callers on how to use and navigate the smartphone mobile application and our secure web portal during all calls. **[MS030]**

[MS044] Describe Policies and Procedures Related to Issuing Member ID Cards within Contractually Defined Timeframes

Aetna maintains policies and procedures (P&Ps) to make certain members received their ID cards within contractually defined timeframes. Policy 4500.15 New, Existing, and Reinstated Member Information describes the process in Aetna's business application system for issuing ID cards to members within five business days of official enrollment notification, and is reviewed

annually, and updated as often as needed. **In 2019, our average turnaround time for issuing member ID cards was 3.6 days.** We mail individual ID cards to each family member enrolled with Aetna. This policy is reviewed annually or as needed due to changes requested by the Department. **[MS044]**

[MS015 – MS017, MS031] Member Handbook Distribution and Updates

Aetna maintains a strong line of communication and partnership with the Department, state agencies and community stakeholders. Our implementation team coordinates with the Department on using and adhering to required templates and timelines to develop and update our member handbook, to include all requirements outlined in the Model of Purchase Service Provider Agreement for State Fiscal Year 2020. **[MS015]** Our member handbook details the following:

- Member rights and responsibilities
- Benefits for all programs and populations served including in-and out-of-network services
- Advance directives
- G&A processes and contact information
- Important phone numbers
- How to access our website and mobile application
- Availability of no cost written translation and oral interpretation services including use of our language line that offers over 240 languages, no cost auxiliary aids and services upon request from members and how to access those services **[MS041]**
- Value-added services (VAS) and descriptions
- Descriptions of and contact information for our MS, CM, Quality Management (QM), and G&A departments
- Tagines in all the prevalent, non-English languages and large print; our taglines explain the availability of written translation and oral interpretation services including TTY/TDD and toll-free numbers for the MS department. **[MS042, MS043]**

Our handbook, available on our website, is also available in English and other prevalent languages as determined by the Department, including Spanish, Chinese, French, German, Arabic, Vietnamese, Korean, Japanese, Tagalog, Italian, Thai, Nepali, Persian, Russian, and Urdu and as requested by members. **[MS041]** We mail handbooks to members, per member

request, within in five business days. **[MS015, MS017]** We notify members at least 14 calendar days in advance of program changes, and mail updated member handbooks as requested by a member and post the electronic version to our member portal in a singular file. **[MS016]** We affirm that we review our handbook at least annually and submit updates to the Department for review and approval, summarizing all changes made during the prior handbook period, along with a 'clean' current electronic version of the handbook. If any additions or changes are needed throughout the year, we request Department approval prior to member distribution.

[MS003] Methodology for Assigning Members to a Primary Care Provider (PCP)

Aetna has local, proven performance in ensuring our members receive the care they need as soon as necessary. Delivering on our **Common Purpose**, our staff extend their reach beyond what is expected ensuring each member gets the right care quickly. We recognize our members' right to make autonomous decisions about their health care providers and if applicable, to maintain relationships with PCPs and specialists already involved in their care. Aetna's methodology for assigning members to a PCP includes member preference, claims history, proximity, and existing relationship(s) with PCPs or specialists. **[MS003]** Our enrollment and PCP assignment workflow reflects the need to maintain relationships with existing health care providers. Members have a right to and can select their PCP at any time by calling MS and making that request. MS representatives make certain each member's preferences, language needs, location of PCP office, and cultural needs, are met. If a new member does not select a PCP with

> Aetna staff make sure each West Virginia member gets the right care quickly. Results of our 2019 Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) demonstrate that children get care quickly (95.92%, above the 90th percentile), secure care, tests, and treatment easily (97.95%, above the 90th percentile), and when necessary, secure care needed right away as soon as needed (98.16%, above the 90th percentile).

the Department at the time of initial enrollment, we assign a PCP, based on the member's existing PCP relationship (if known), location/proximity, claims history, language needs, and cultural needs. The system can also be utilized to assist with auto-assignment using the following criteria:

- **Members with previous, active Aetna enrollment:** If a member has previous enrollment in our internal system with an active PCP per review of our claims history, we auto-assign that PCP to the new enrollment
- **WVCHIP members:** WVCHIP members are identified on our monthly enrollment roster and will be auto-assigned a PCP accordingly. When members call, MS representatives will educate members of the benefits of having a PCMH when calling for PCP selection, including waived co-payments and integrated, holistic care, customized to serve children and youth.

Figure 6.5.1-2 illustrates how multiple processes run concurrently to make sure accurate and timely PCP assignment, reconciliation, and delivery of the member's welcome packet.

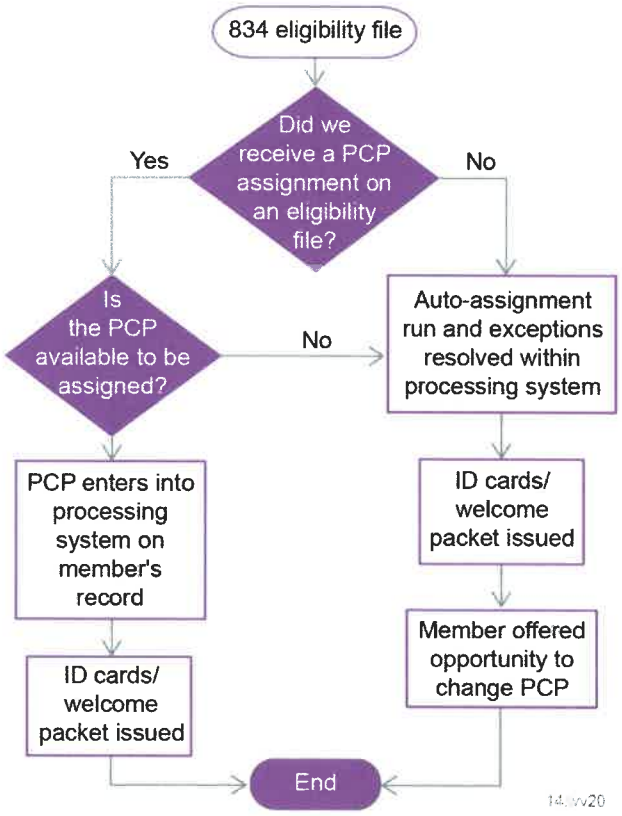


Figure 6.5.1-2: New Member Enrollment, PCP Assignment, and Welcome Packet Workflow

Aetna is equipped to effectively manage PCP assignment and distribution of the member welcome packet for our valued MHT, WVHB, and WVCHIP members.

Our members can be reassigned upon their request to a PCP that best meets their treatment needs. MS representatives are fully trained on PCP requests and the member's right to change PCPs. Representatives make sure each member's preferences are reflected in PCP choice, including language needs, cultural

needs, and location of the PCP office. All requests for PCP reassignment will be fulfilled within two days of the initial request, they are effective immediately, and the member's updated ID is issued within five days. Aetna members can also use the secure member portal on our website or their smartphone mobile application to request or make a PCP change.

[MS004] Protocols to Notify Members of PCP Assignment

Aetna uses multiple methods to notify members of their PCP assignment, and it is printed on their member ID card. PCP assignment is verbally confirmed during calls to the MS department, and this information is available via our secured web portal and secure mobile application.

[MS004] We develop protocols for notifying members of their PCP assignment based on the Model Purchase of Service Provider Agreement for State Fiscal Year 2020 required timeframes, the Department's 834 enrollment process, the unique needs of the population served, and capabilities of Aetna's management information systems for enrollment. As required, member enrollment materials are issued within five days of enrollment. For members enrolled in our WVCHIP program, we will inform members of waived co-payments for choosing a PCMH as a PCP provider in our member materials and verbally, during calls. For members who are enrolled in CM, Aetna's care manager conducts additional follow-up communication as needed with members to inform them and verify their PCP assignment and will assist in making changes as needed. Care managers identify and assist in appointment scheduling and complete follow-up calls to make sure members attend. When telephonic outreach is not successful, care managers use alternate strategies, email, text, and mobile application messaging for communicating with members. If members do not have telephones, we offer our members a no cost, Lifeline smartphone, ensuring immediate access to member information. We offer advice about how to

locate adequate smartphone service and where members can locate access to no cost internet resources, including computer access for using the secure member portal.

[MS005] Educating Members of the Right to Change PCPs

Members are notified of their rights, including the right to change PCP in our welcome packet and the member handbook. Members are also notified during interactions with any member-facing departments such as MS, CM, G&A, and other Aetna departments. When members call the MS department, representatives fully trained on member rights can easily and quickly assist members with PCP changes. Care managers can facilitate PCP changes during in-person visits by demonstrating the functionality on the Aetna smartphone application, by using the secure member portal, or by assisting the member to call the MS department. **[MS005]**

[MS033 – MS039] Aetna's Secure Member Portal and Benefit Information

In addition to the ability to call us 24/7/365, Aetna offers multiple ways for members to access their individual benefit information including via our secure member portal located on our website and Aetna's mobile application for smartphones. Members can easily navigate their personal medical records, services, and service authorization status by logging into our secure member portal. Members can call our MS line for assistance in logging onto the portal or mobile application. Each member's individual member portal contains personalized medical records, authorization status(es), temporary ID cards, and confirmation of a PCP. **[MS034, MS035, MS037, MS038]** Aetna has the capability to add cost sharing to our secure member portal and will be added for our WVCHIP members. **[MS036]** Members enrolled in CM programs such as members who are pregnant or members with substance use disorders have access to additional CM information including program-specific tools, text campaigns, and the ability to directly reach their care manager. Aetna's member portal is secure and confidential. We provide a tool to

make sure guardians have access to the member portal on a case-by-case basis when necessary. Once provision of access is determined, guardians can access comprehensive information about the care of the member they support and view electronic health record and health passport information. **[MS039]** Aetna's mobile application for smartphones offers easy and immediate access to critical member information when members need it. Members can view personalized information in the application, including the member ID card, their individualized medical record, medications, care plan, claims and authorization status(es), cost sharing information, temporary ID cards, and confirmation of their PCP.

Aetna's publicly accessible website offers a wealth of resources and educational information. It is a single, comprehensive, source of easy-to-navigate information for our members' needs. Our public website includes information and links to useful member resources including our secure member portal, covered and VAS, provider search, CM programs, important telephone numbers (e.g., MS, the BH Crisis line and the Health Information line), the member handbook and member rights, health education and prevention information and programs, a community resource library, Aetna's smoking cessation program, and member newsletters. Members can provide feedback about our website. We have a robust, responsive approach to member feedback including responses within 24 hours and taking related action to support a better member experience.

Member Rights

MS020	The Vendor should describe how they will ensure they are meeting customer use and report to the Department on customer service performance standards including, but not limited to, the following:
MS025	Turnaround time for member requests
MS032	The Vendor should describe how they will make information available for members who have Limited English Proficiency (LEP) or limited reading skills, as indicated

	per 67 Federal Regulation (FR) 41455 (https://www.govinfo.gov/content/pkg/FR-2002-06-18/pdf/02-15207.pdf).
MS040	The Vendor should describe its process to inform members that program information is available in paper form without charge upon request and available within five (5) business days.
MS041	The Vendor should describe how they will make auxiliary aids and services, as well as oral interpretation services, available in all non-English languages to all members and potential members, free of charge, including the top fifteen languages spoken in the State, which are Spanish, Chinese, French, German, Arabic, Vietnamese, Korean, Japanese, Tagalog, Italian, Thai, Nepali, Persian, Russian, and Urdu.
MS042	The Vendor should describe how they will notify members that oral interpretation services are available for any language, and that written information is available in prevalent languages and braille, and how to access those services.
MS043	The Vendor should describe how they will include taglines in all written materials in the prevalent non-English languages and large print (in a font size no smaller than eighteen [18] point) explaining the availability of written translation or oral interpretation and the toll-free and Text Telephone (TTY)/Telecommunication Device for the Deaf (TDD) telephone number of the Vendor.

The percent of adults in West Virginia who have a disability is higher than the national average. According to the Centers for Disease Control and Prevention[2], 39.2 percent of adults who live in West Virginia have some type of disability versus 25.6 percent of adults who have some type of disability in the United States. This high burden spans disability types: mobility, cognition, independent living, hearing, vision, and self-care and is correlated in West Virginia and the United States with inactivity, high blood pressure, smoking, and obesity. Aetna has proven, demonstrated, local experience—over 23 years in West Virginia—offering and promoting member rights such as access to quality-driven

Aetna's superior performance in the delivery of quality-driven, member-centric services that promote member rights and enhance West Virginians' continuity of the care they deserve is demonstrated in our External Quality Review Organization (EQRO) performance: we scored 99% in 2017 and 100% in 2015, 2016, and 2018.

[2] Centers for Disease Control and Prevention, "Disability and Health U.S. State Profile Data for West Virginia (Adults 18+ Years of Age)," Centers for Disease Control and Prevention: accessed January 2020; www.cdc.gov/ncbddd/disabilityandhealth/impacts/west-virginia.html.

care for members with disabilities. Our policies, practices, support, and community and member engagement address the health risks associated with disability and poor health and support the Department's goals for enhanced coordination of care and access to services, reduced fragmentation, and seamless continuity of care.

Our superior performance begins with strict adherence to regulations for ensuring and promoting member rights via strict compliance with State and federal regulations and the Model Purchase of Service Provider Agreement for State fiscal year 2020. We promote member rights in all we do, including every member-facing interaction and our written communication to members, providers, and stakeholders. All Aetna internal staff leverage all telephonic and email/mail/written communication, media, and in-person opportunities to educate members about their member rights. We include links to our member handbook, outlining member rights, on our Aetna website. Aetna MS hotline staff, our member advocate, care managers, and other internal staff educate callers about how to find member rights on the member website during individual calls or in-person interactions, as necessary. Aetna is and will be compliant with all requirements outlined in the detailed specifications including the following:

- Making information available in our Welcome packet, website and member handbook for members who have Limited English Proficiency (LEP) or limited reading skills **[MS032]**
- Having processes to inform members that program information is available in paper form free of charge upon request within five business days **[MS040]**
- Making auxiliary aids and oral interpretation services available free of charge for the top fifteen languages spoken in the Department (Aetna's oral interpretation services offer over 240 languages) **[MS042]**
- Notifying members how to access and the availability of oral interpretation and written translation services in prevalent languages and Braille **[MS041, MS042]**
- Ensuring processes for including taglines on all written materials in the prevalent, non-English languages, large print explaining the availability of written translation or oral interpretation and toll-free TTY/TDD telephone numbers. **[MS042, MS043]**

Aetna maintains written P&Ps formally acknowledging member rights and responsibilities and communication methods to inform members and providers of those rights and responsibilities.

Our policies include specification of rights such that each member has a right to the following:

- To receive information in accordance with standards that promote member understanding of managed care services; for example, in January 2020, one of our MS representatives made sure a member who requested the member handbook in Russian received the translated handbook in required timeframes
- To be treated with respect and consideration of their dignity and privacy
- To accessible services; Aetna makes certain our adherence to federal and state regulations that specify physical and communication accessibility and other federal standards for persons with disabilities or persons with limited English proficiency (LEP); **[MS032]** our providers are required per contract to adhere to provisions that meet the American with Disabilities Act and other federal standards; Aetna makes certain access to written translation and oral interpretation services including ASL, Braille, prevalent languages, and large print; our website and secure member portal are Web Content Accessibility Guideline compliant, which promotes standards for ensuring web content is accessible for persons with disabilities. **[MS042]**
- To choose providers from among those affiliated with the managed care organization (MCO)
- To participate in decision-making regarding their health care, including the right to refuse treatment
- To receive information on available treatment options or alternative courses of care, presented in a manner appropriate to the member's condition and with consideration for social or other supports needed to fully understand; when necessary, our member advocate offers electronic, telephonic, and in-person outreach and linkage to community and social resources to assist members in navigating managed care processes, ensuring member rights
- To request and receive medical records and to request that they be amended or corrected, in accordance with the privacy rule as set forth in 45 CFR parts 164.524 and 164.526, upon their effective dates, to the extent they apply
- To obtain prompt resolution of issues raised by the member, including complaints, grievances, or appeals and issues relating to authorization, coverage, or payment of services; **we resolve member issues quickly and effectively** – MS staff address and resolve member issues immediately on the initial call to the MS line and when necessary, document and forward all formal complaints, grievances, and appeals to the appropriate departments for timely resolution
- To offer suggestions for changes in P&Ps

Our Member Services staff resolve member issues quickly and effectively. In 2018 and 2019, we resolved nearly 100% of calls to our Member Services line during the initial call.

- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion, and
- To be furnished health care services as set forth in this contract

We protect and promote these rights by including taglines on all written member materials for West Virginia prevalent languages and large print, explaining the availability of written translation and oral interpretation services including TTY/TDD and toll-free numbers. We review all member materials prior to distribution for a sixth-grade reading level, and we make certain that member rights such as member privacy, accessible services, and provider choice, are included in our written policies. **[MS042, MS043]**

Our procedures make sure confidentiality of medical records is upheld and any other health and enrollment information that identifies a particular member in accordance with federal and State regulations. We make certain that all services, both clinical and non-clinical, are accessible to all members, including those with LEP or limited reading skills, with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities. **[MS032]** We understand the importance of member decision-making for provider and specialty services as well as provider continuity for members with special healthcare needs. We allow each member to select their

PCP from among those accepting new Medicaid members. We encourage our members and our member's parents or legally authorized representative to fully participate in decision making related to care. When necessary, our member advocate offers additional telephonic or in-person support to aid in promoting full participation.

Approximately 91% of our provider network currently have open –panels and accepts new Medicaid members.

[MS032] Information for Members with Limited English Proficiency

Aetna has over 23 years of local experience serving our valued members in West Virginia including ensuring information for members with LEP and limited reading ability can access and understand Aetna member materials. **[MS032]** We are compliant with 67 Federal Regulation (FR) 41455 and the Model Purchase of Service Provider Agreement for State fiscal year 2020. For our members with LEP or limited reading ability, having a prevalent non-English language can be a barrier to understanding benefits, accessing needed services, understanding or exercising rights, and/or fully participating in healthcare related activities. We take full responsibility to make sure our members with LEP and limited reading skills have meaningful access to all Aetna programs and services through published guidance consistent with federal guidelines. Aetna uses multiple strategies to make certain information is available for members with LEP including training MS and CM staff, our member advocate, and other health plan staff on member rights and the use of interpretation or translation services and offering written materials in prevalent languages, ensuring delivery in required timeframes. MS, CM, and other health plan staff are fully trained in understanding member rights and utilizing written translation and oral interpretation services. **[MS042]** For example, if a member calls the MS department using a prevalent non-English language, our representatives are notified that the caller is non-English-speaking and immediately engage our subcontractor for interpretation services on a three-way conference call, ensuring communication in the member's prevalent language. If a member is deaf or hard of hearing, MS and other health plan staff immediately engage with the TTY/TDD interpreter for proper communication. Aetna publishes vital member materials at a sixth-grade reading level and in prevalent languages at direction of the Department and per member request. This includes but is not limited to publication of our member handbook,

translation of a member's individual treatment plan, and if necessary, as directed by the Department or in response to West Virginia's community needs, publication of our website.

[MS040] Informing Members of Paper Copies within Timeframes

Aetna is 100% compliant with issuing paper copies within Department required timelines.

Aetna adheres to all federal and Department regulations as well as the Model Purchase of Service Provider Agreement for State Fiscal Year of 2020 requirements for informing members of their right to paper copies within required timeframes. Aetna staff follow the process written in our P&Ps to inform members that program information is available in paper form without charge upon request and available within five business days. **[MS040]** Our representatives educate members during calls to the MS department. We provide written notification of this right in our member handbook, in our welcome letter, in the written correspondence that accompanies a member ID card, and on our website.

[MS041] Auxiliary Aids and Oral Interpretation Services

Aetna uses multiple strategies to make certain auxiliary aids and services and oral interpretation services are available to our members and potential members at no cost, and we offer additional support, when needed, in the form of assistance by our member advocate. **[MS041, MS042]** Aetna subcontracts with a qualified subcontractor that offers oral interpretation and written translation services. Our subcontractor offers language access in more than 240 spoken languages and ASL, delivering high quality, accurate, professional interpretation sessions and translation results. These languages include the top fifteen non-English languages identified by the Department in this requirement and spoken in the State (i.e. Spanish, Chinese, French, German, Arabic, Vietnamese, Korean, Japanese, Tagalog, Italian, Thai, Nepali, Persian, Russian, and Urdu). **[MS041]** Our contractor has been designated as a trusted business partner

for competent language access in the healthcare industry and offer certified interpreters who apply and once hired, are tested, trained, and tested again for competency. Whenever necessary, Aetna MS and CM staff, our member advocate, or other staff can immediately access our subcontracted services based on member need. During telephonic interactions, once a member indicates that they speak a non-English, prevalent language, Aetna staff initiates a three-way conference call to our language line vendor and we make sure the caller's issues are understood, communicated, and adequately addressed. Aetna staff are fully trained on the steps to engage our oral interpretation services including use of TTY/TDD. Health plan staff assist members by arranging for interpreter or written translation services on the member's behalf, whenever it is needed. Our member advocate is responsible for ensuring members can obtain member materials in alternate formats when involved in member interactions and can provide additional support whenever a need is identified. Members can call us whenever oral interpretation services are needed, for example, at a provider appointment, and representatives assist the member in arranging for appropriate services.

[MS043] Taglines for Written Materials

Aetna adheres to federal and state regulations and the Model Purchase of Service Provider Agreement for State Fiscal Year 2020 that outline requirements supporting member rights including taglines for written materials in prevalent, non-English languages and large print explaining the availability of written translation or oral interpretation services and the toll-free TTY/TDD telephone number on all our written materials. **[MS042, MS043]** Our process for compliance to these regulations and requirements, include tagging all member materials such as our member handbook, our website, member newsletter, and CM written materials (e.g., the member's care plan), and notices of action/adverse benefit determinations.

[MS042] Notifying Members of Interpretation and Translation Services

Aetna has written P&Ps that support timely and accurate notification of interpretation and translation services, and how to access those services. Aetna notifies members of the availability and how to access oral interpretation and written translation services including ASL and Braille whenever necessary in member-facing interactions and via written publications such as our member handbook and member portal. **[MS042]** We make sure that interpreters meet members at all appointments for physical, behavioral, dental, and vision health and include written notification of accessing services via our MS department in our member handbook.

[MS020, MS025] Member Grievances and Appeals

Aetna recognizes the need for additional oversight of the quality of and access to care for our members in support of ensuring Department goals for enhanced coordination, access to care, and reduced fragmentation. We **demonstrate our superior performance promoting member rights through our member G&A system.** We include, inform, and partner with the Department and other state agencies when issues are identified and utilize our member advocate to provide the additional support necessary for members. Our member advocate is responsible for interacting with members and connecting to appropriate resources, specifically: collaborating with CM teams; providing member support related to enrollment, access, or continuity of care issues; supporting members through the grievance and appeal process; and assisting members to obtain materials in alternate formats. We make sure our contract liaison/MHT administrator monitors grievances and appeals, and implements policy level,

Aetna's superior performance in adhering to and promoting member rights is demonstrated in our 100% External Quality Review Organization (EQRO) score for 2018. This review included a detailed review of our member grievance and appeal system including policies on member complaints, grievances, and appeals, the member handbook, and notice of action, grievance, appeal, and adverse determination records.

operational, and training or program changes necessary to meet the needs of the MHT, WVHB, and WVCHIP program.

Aetna's MS department plays an important and critical role educating our members about G&A rights and procedures. We thoroughly train our MS representatives, CM team, and our member advocate about G&A policies, procedures, and Department requirements, ensuring all Aetna points of contact are opportunities to advocate for the rights of our valued members. Guardians, legally authorized representatives including any designated person such as a family member, friend, guardian, PCP, or an attorney are educated on grievance and appeal information located in our member handbook, online via our website, and by calling the MS department. Aetna's G&A system goes beyond basic requirements to foster a culture of high-quality performance throughout our operations, promoting member engagement and self-sufficiency. The specific elements of our approach discussed throughout this section describe Aetna's core processes to safeguard member rights and enhanced capabilities, demonstrating that Aetna not only fully meets the requirements of the West Virginia statutes, but exceeds and will continue to exceed the Department's expectations.

Aetna complies with all requirements and principles of the G&A system, including compliance with all Department requirements and state and federal laws and regulations referenced therein, including, but not limited to, Model Purchase of Service Provider Agreement for State Fiscal Year 2020, West Virginia Statutes 33-25A-12 and 42 C.F.R. §§438 Subpart F. Aetna retains responsibility for all G&A processing, investigations, and resolutions/decisions except for dental services, which are delegated to our dental subcontractor and monitored according to requirements for delegation oversight.

Aetna maintains a comprehensive G&A system, including State Fair Hearings, supported by our **NCQA commendable rating. We have established G&A processes that are further supported with Medicaid best practices acquired through our Medicaid experiences in 16 states.** We leverage our experience and best practices to make certain we meet and exceed the requirements in West Virginia.

Filing and Resolving a Grievance or Appeal

Members, their representatives, or the legal representatives of a member's estate may file a grievance or appeal in person, by telephone, fax, voicemail, email, through the website, or in writing. We assist members in filing grievances and/or appeals, if requested, or if we identify a need. When necessary, our member advocate is assigned to provide additional support for any steps involved in the filing or resolution of a grievance or appeal. **Figure 6.5.1-3** illustrates a high-level workflow of our member grievance process and **Figure 6.5.1-4** illustrates a high-level workflow of our member appeal process.

Continuous Quality Improvement in Alignment with NCQA Standards

Aetna makes certain continuous quality improvement occurs through accountable monitoring and follow-up processes that are in alignment with NCQA standards. In 2019, our Service Improvement Committee identified a complaint trend regarding billing members. We developed a desktop procedure and identified a system for tracking these complaints. Our MS representatives made outbound calls to providers for each identified complaint, explaining proper Medicaid billing. Resolved complaints were sent to our G&A department for trending. Our Provider Relations team made outbound calls to providers with high rates of unnecessarily billing members for further technical assistance.

Member assistance may include auxiliary aids and services such as interpretation services and numbers that have adequate TTY/TDD and interpreter capability. **[MS041]**

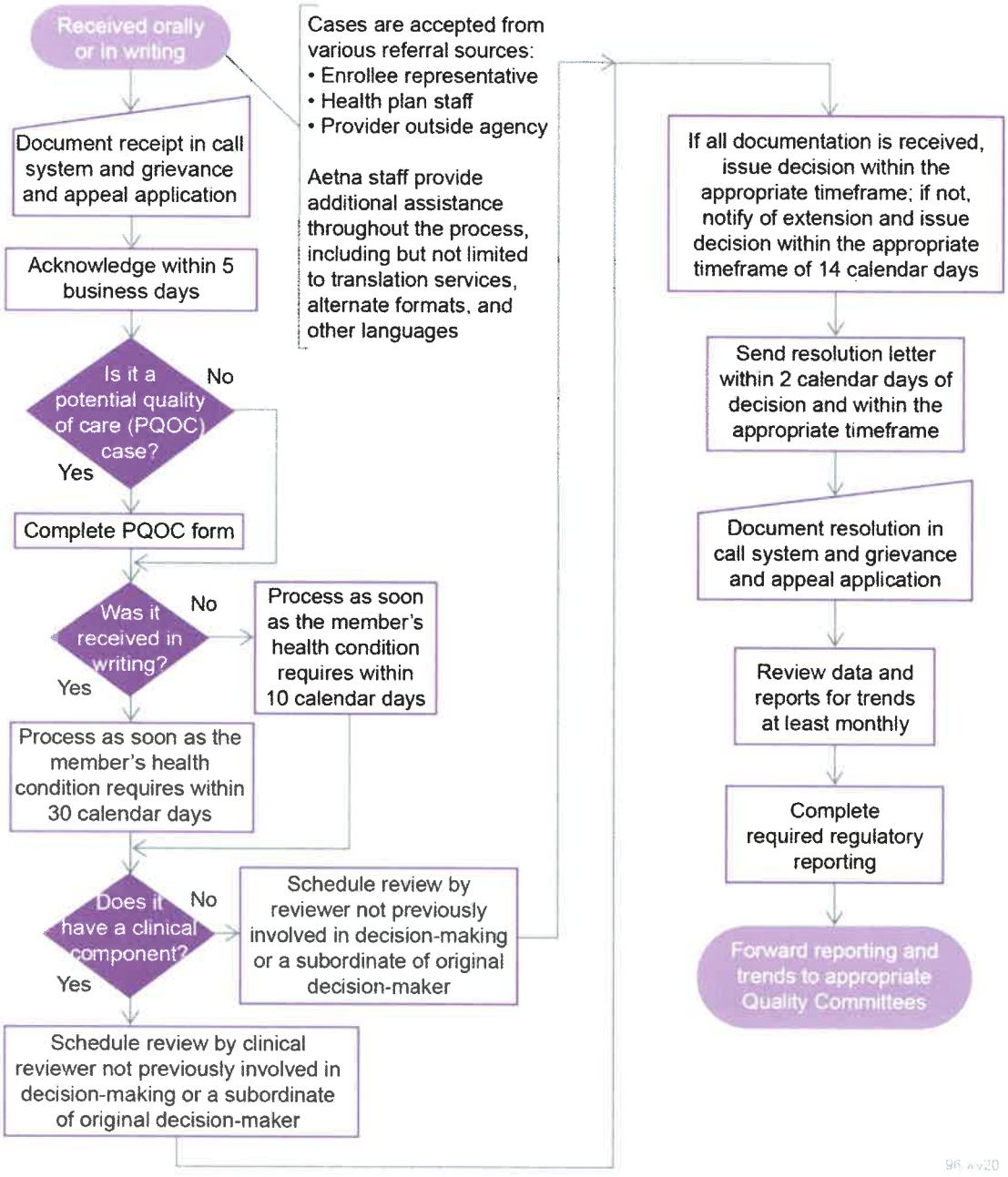


Figure 6.5.1-3: Aetna High-Level Grievance Process

Aetna's detailed, compliant member grievance process promotes and helps to ensure the rights of our valued members.

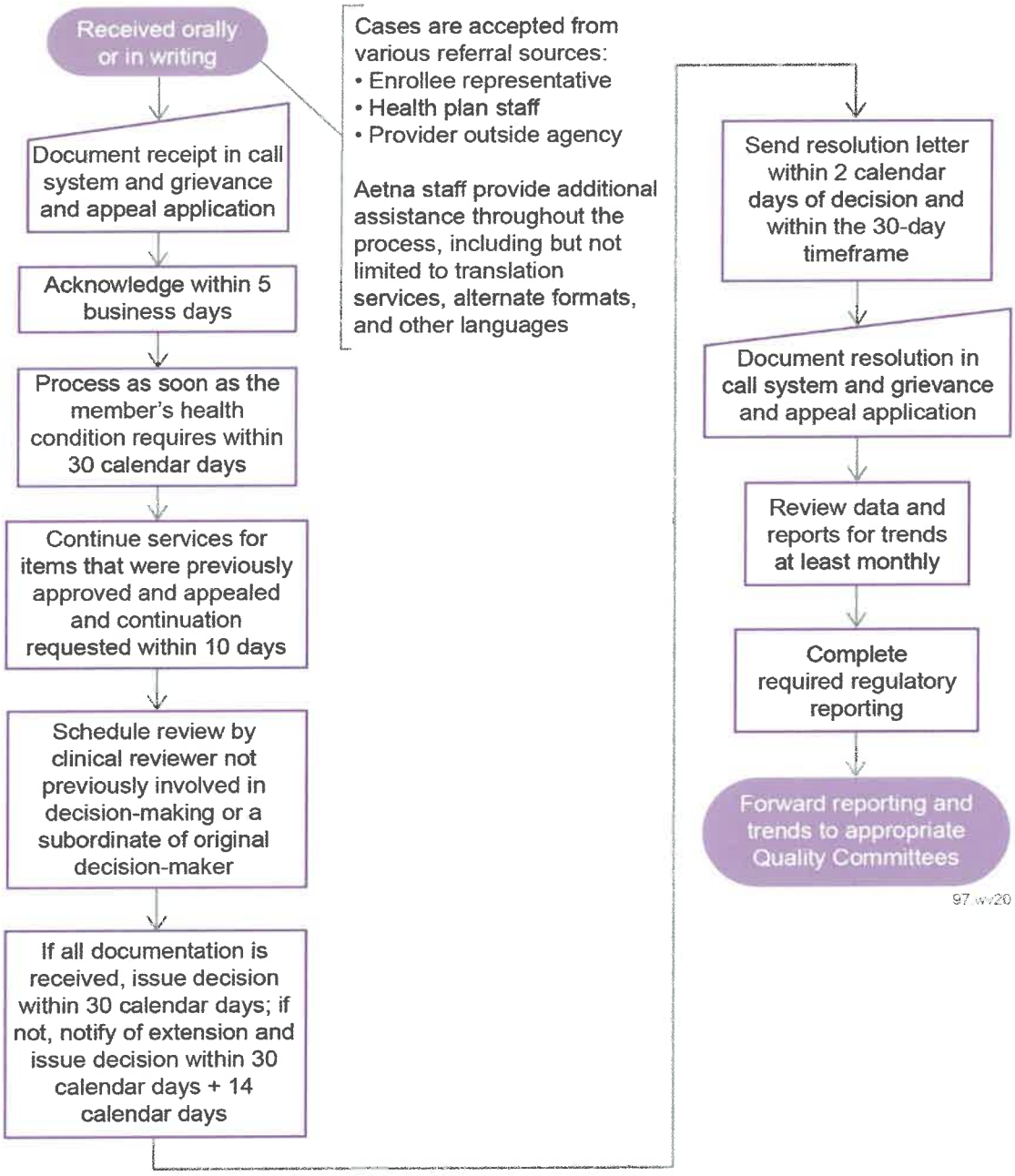


Figure 6.5.1-4: Aetna High-Level Appeal Process
Aetna's detailed, compliant member appeal process promotes and helps to ensure the rights of our valued members.

Our published member communication materials inform members how to designate a representative to act on the member's behalf at any time during the G&A process. To verify the

authority of designated representatives, Aetna requires written authorization signed by the member unless the person is a legally designated representative (e.g., parent, guardian, and conservator). Members or their authorized representative have the right to examine the member's case file, including medical records and any other documents and records considered during the grievance and appeal process, and may request copies of all documents at no cost. They may also present supporting documentation or evidence by phone, in person, or in writing on or before the date of the grievance or appeal meeting date.

To present information, the member or their authorized representative contacts the G&A department. The parties to the grievance or appeal include the health plan, the member, and their representative or the representative of a deceased member's estate.

[MS020, MS025] Data, Reporting, and Trending

Aetna's G&A records are housed in our inclusive system, which includes all correspondence, letters created, and staff actions taken on the case. MS staff receive updates on G&A trends via email and during staff meetings, including any policy or program changes supporting those trends. For example, representatives were recently trained on the updated procedures for capturing complaint and dissatisfaction information, ensuring full understanding of each member's complaint or issue. MS staff use this information to educate members as needed. Our tracking system allows us to capture and report on all information, as outlined in 42 CFR 438.416. Our system contains a standard suite of reports and queries by case type of complaint, grievance, appeal, or State Fair Hearing that we utilize to track cases throughout the process. To support the accuracy and integrity of our G&A data and reporting, Aetna has programmed its G&A

In 2019, Aetna helped to ensure appropriate decision-making during member appeals as demonstrated by having three State Fair Hearings, of which two included decisions upheld by the Department.

application to automatically calculate the due date for completion of the case, to avoid data entry or staff errors in calculating due dates. The application uses this due date when calculating the actual turnaround time on completed cases and, upon resolution, automatically marks the case as timely or untimely.

The G&A manager utilizes standard queries and reports within the application to monitor cases in real time to make certain of timely and accurate resolutions, and to manage staff workloads, including reassignment of cases during unscheduled absences such as staff illness. This includes monitoring and reporting on member request turnaround times (TAT). **Our 2019 TAT for member appeals was nearly 99 percent timely. [MS020, MS025]** If we see any evidence of an issue requiring escalation, we act on it immediately. For example, the aging report displays all cases in real time and gives their age from received date and time to date and time of the report run in calendar days. All follow-up actions such as member phone calls and the overall age of the case are color-coded in each staff person's work queue. Cases that are past due display in red, those due in 48 hours display in blue, and those due in greater than 48 hours display in black. This visual display along with traditional reports allows easy real-time identification of cases and work to be completed.

All calls received from members or their authorized representatives are tracked in the main operating system. Within that system is a call tracking module that automatically assigns the date of documentation and allows for the MS representative to document the full content of the call. Regardless of whether the MS representative can resolve the member's or their authorized representative's issue, call tracking is assigned to the G&A department. The G&A department reviews the call work queue a minimum of three times per day to begin processing any

grievances or appeals received as quickly as possible. Any case that was resolved by the MS department is documented and closed for tracking and trending. Any case that was not resolved by MS is documented in the G&A application and the formal process begins. Upon resolution of the grievance or appeal case, the call-tracking system is updated with basic information such as date of decision and the decision of 'overturn,' 'upheld', or 'partial uphold.' This information allows MS staff to be able to answer status calls in the event a member calls to check on the status of their case. It also maintains compliance with Healthcare Insurance Portability and Accountability Act regulations of communicating the minimum amount necessary for representatives to do their job. If the member has detailed questions the call will be transferred to the G&A staff who is processing the case.

Aetna is committed to our partnership with the Department on behalf of any new populations served including WVCHIP and will invite Department staff to participate on our Service Improvement Committee (SIC), ensuring communication at state and policy levels about grievance and appeal trends and related operational or program changes.

Ensuring High-Quality Services

We recently had a member submit an appeal for her child who had complex health issues. We engaged care team participants including the head of pediatric cardiology services at the preferred provider, the care manager, and other involved staff to participate in multiple meetings and reviewed what was in the best interests of the child. After several discussions, we determined care at the mother's preferred provider was best for the member and authorized services, ensuring quality-driven care.

Member Assessment

MS002	The Vendor should describe how they will leverage information technology (IT) solutions to improve access to member information.
MS006	The Vendor should describe its process for conducting initial and ongoing assessments appropriate for members' circumstances and needs including, but not limited to, the following:
MS007	Methods utilized to complete assessments, and variances by risk level

MS008	Timeline to complete assessments, and variances by risk level
MS009	Identification of the trigger(s) for completion of a comprehensive assessment
MS010	How assessments will be used to develop and update treatment plans and confirm the risk stratification level for each member
MS011	How data from a member's Primary Care Provider (PCP) will be used to prevent duplication of assessment efforts and assist with identification of priorities for the member
MS012	How a member who cannot be reached or who refuse assessments will be handled by the Vendor, including multiple contacts if initial contacts are unsuccessful
MS013	How assessment data will be stored and made available to members of the care team in order to coordinate care
MS014	How assessment data will be shared with a member's other payer(s), as applicable, in order to prevent duplication of efforts

Aetna offers excellence in our care management infrastructure through localized programs delivered by West Virginians as part of our regionalized **Care Connections** program and teams. Our Care Connections teams include robust staff of experts and approaches that provide the right amount and kind of support to members who need it most.[3] We promote self- and family-sufficiency, recovery, and resiliency using person-centered CM approaches that allow for comprehensive assessment of individual members. Our Care Connections framework is fully integrated and includes evidence-based, comprehensive assessments of members' physical, mental/behavioral, social, and family needs that drive effective care and treatment planning. With West Virginia's high incidence of opioid misuse, chronic diseases, and related social needs, we make certain to include social determinants of health (SDOH) such as food insecurity or lack of transportation as part of our treatment planning process, assuring access to whole person care. We have an established trauma-informed care process which promotes member

[3] We refer to our care management program and teams/staff for the remainder of the Member Services section as the Care Connections program and Care Connections staff. This includes but is not limited to the following staff: clinical care managers who are licensed nurses, counselors, or social workers; care management coordinators; care management associates; and where necessary, our supervisors and medical directors.

achievement of optimal health outcomes. Our process for assuring completion of comprehensive assessments appropriate for each member's individual circumstances and needs includes tailoring our methods and timelines for completing comprehensive assessments to the needs of West Virginians. This includes utilizing stratification tools that support all levels of need and include triggers and information-technology solutions for comprehensive assessments, and utilizing integrated, person-centered assessments and treatment plans stored and shared in electronic formats easily accessible in near real-time by the care team, members, providers, and when necessary, other payers for timely, seamless coordination of care.

[MS006] Conducting Initial and Ongoing Assessments

Aetna's process for conducting initial and ongoing assessments appropriate for each member's individual circumstances and needs includes the following:

- Staffing our Care Connections department with employees who offer a robust variety of experience, education, and skill across health care environments including medical, nursing, BH, substance-use disorder, lived experience, specialty care, and recovery and resiliency
- Offering a comprehensive training program customized to the unique needs of West Virginians and informed by our national expertise on trauma-informed care, recovery and resiliency, SDOH, person- and family-centered approaches, cultural sensitivity, and use of evidence-based assessments
- Supporting our **Care Connections** department with a **System of Care (SOC)** approach that includes health plan staff dedicated to address and remove barriers in the larger Medicaid system of care
- Timely screening and stratification into CM tiers that support members' unique needs including timely assignment of a dedicated Care Connections staff for members with complex needs
- Completion of comprehensive, evidence-based, customized assessments that occur within 30 days of initial screening and drive quality-drive treatment planning **[MS008]**
- Completion of additional comprehensive assessments at least annually and any time a significant life change occurs or a member's needs change, which includes adding members in new or additional Care Connections programs as indicated **[MS006]**

[MS007, MS008] Methods and Timelines to Complete Assessments and Variances by Risk Level

As the first step in completing assessments that occur within 30 days of initial screening **[MS008]**, we make sure that we hire and staff our **Care Connections** department with employees who offer the experience, education, and skill necessary to engage and guide our members toward attainment of a meaningful quality of life, optimal health, and overall wellness. **[MS007]** Our Care Connections teams are regionally located in West Virginia communities and include CM associates and CM coordinators, who support intake, screening, and care coordination. Care Connections teams also include clinical care managers—registered nurses and licensed clinical social workers and counselors—who have extensive experience and training in conducting assessments, facilitating integrated care planning, utilizing clinical models, navigating the Medicaid and WVCHIP systems, and conducting ongoing care coordination. Our Care Connections teams are guided by medical directors licensed in West Virginia—local, health care experts—who understand the resources needed and effective strategies that support stability, build on members' capabilities, and help members achieve their life goals, in collaboration with provider, stakeholder, and community partners.

Our existing Care Connections teams include specialized staff who live and work in local, West Virginia communities and possess the expertise and education to address the unique circumstances of our members. **[MS007]** Care Connections teams are **locally based in each of West Virginia's regions** and include supervisors, clinical care managers, CM coordinators, CM associates, substance use disorder (SUD) specialists, obstetric specialists,—experts in prenatal and maternal care, utilization management staff, supervisors, and concurrent review clinicians. Our team offers an array of clinical experience in **pediatrics, BH, oncology/hematology,**

neurology, nephrology, ophthalmology, cardiology, surgery, and trauma care. Given the high prevalence of substance use in West Virginia and the negative impact substance use has on health, we employ **SUD specialists**—registered nurses, licensed social workers, and licensed counselors—who offer expertise on regional resources and referral processes related to substance use and SUDs. These specialists are responsible for assessment and treatment planning as well as developing a proactive course of action that removes barriers and enhances overall wellness. Our department also employs one **special needs representative and one peer support specialist,** who have lived experience in SUDs, trauma, and supporting families. Our peer support specialist primarily offers telephonic and in-person services in our central and western regions but as necessary, is available statewide to provide support to our members.

Given the high prevalence of SUDs as a contributing factor to trauma and poor health, our peer support specialist connects with members offering an empathetic bridge to member engagement in our Care Connections program. Our special needs representative and peer support specialist receive specialized training and participate, when requested by members, in the assessment and treatment planning process, offering critical perspective on both and linking members to community resources.

Aetna's co-located relationships foster seamless access to care and enhanced coordination. Our teams are co-located with providers in the following regions:

Northern: Chestnut Ridge, Weirton Hospital, Wheeling Hospital, and West Virginia University Ruby Memorial

Central: CAMC General Hospital, Women and Children's Hospital, Memorial Hospital, and OB GYN Center, Dr. Ammar Shammaa/Women's Care Clinic, St. Francis Hospital, and Thomas Memorial Hospital

Western: Camden Clark, Dr. James Bailes/Cabell Huntington Pediatrics, Edwards Comprehensive Cancer Center, Lily's Place, and Marshall Health

Southern: Beckly Appalachian Regional Hospital, Dr. Ammar Shammaa/Logan West Virginia, Greenbrier Valley Medical Center Mercer County, Pavilion, and Williamson Health and Wellness Center

Where community needs indicate, we partner with the Department and collaborate with providers to identify and implement staffing solutions that meet the needs of West Virginia communities. We have specialized Care Connections programs for pregnancy, teen pregnancy, at-risk youth, children with special needs, and chronic conditions such as diabetes, asthma, and obesity. Aetna has well-established, locally based Care Connections teams in each region of West Virginia that are experts in regional health care needs and available services. This includes **staff who are co-located at provider offices in the northern, central, western, and southern regions, offering seamless access to care and enhanced coordination of care.** **[MS007]** Aetna also collaborates with community health workers (CHWs), who are local to West Virginia neighborhoods that link members to community resources. When necessary, when the CHW is working with someone and their circumstances change, CHWs can refer to Aetna's supportive or intensive CM services. For example, CHWs at **Williamson Health Wellness Center** in Mingo County engage and educate members who are newly diagnosed with chronic diseases such as diabetes into our intensive, disease-specific CM programs.

As the next step in completing assessments, we conduct comprehensive initial and ongoing training. **[MS007]** Upon hire, staff are trained on a variety of content areas, processes, and approaches through live training sessions and online modules. Our *Integrated Care Management Basics for Care Managers* manual is provided to new employees and reviewed during the initial training phase and includes topics such as the role of a care

Aetna collaborated with Partners in Health to provide critical training and an emergency department (ED) diversion program for providers who offer SUD services. We sponsored $30,000 to Partners in Health that supports training in medication-assisted treatment and supports development of a program for ED diversion, connecting members to the right level of provider care, support, and resources in the local community.

coordinator and the interdisciplinary care team; assuring appropriate care transitions and discharge planning; assessing physical, social, and behavioral risks and needs using evidence-based tools; recovery and resiliency; SDOH; person- and family-centered approaches; cultural sensitivity; providing member education on complex conditions and wellness programs; requirements for frequent contact by program; developing and updating treatment plans; community resources and referrals; P&Ps; and documentation standards. Clinical training topics include but are not limited to trauma-informed care; motivational interviewing; Mental Health First Aid (MHFA); cultural sensitivity; gaps in care; assessment and treatment of SUDs; BH services; SDOH; addressing obesity in individuals with mental illness; national diabetes prevention program; member rights; utilization management clinical guidelines and medical necessity; confidentiality; service excellence; and information systems training as it relates to the documentation, storage, and sharing of screenings; assessments; and treatment plans with members of the care team and in our electronic CM system. Staff receive ongoing monthly and quarterly training through online modules and are encouraged to attend external conferences as required for licensure.

We also offer support to our Care Connections staff, who operate within the context of our **SOC model**. Our SOC model is an Aetna approach to organizing and staffing our local health plans with administrators whose responsibility is to collaborate with stakeholders and providers on best practices for reducing the inequities and barriers present in our health care delivery system that impact access to quality-driven care. This includes having designated health plan administrators to focus specifically on specialty areas, such as adult services, children's services, and recovery and resiliency approaches. Our Care Connections staff are supported by

our existing West Virginia SOC staff who collaborate with the Care Connections department on a system level. Our SOC is defined as a team of specialty administrators whose primary goal is to reduce barriers, improve access, and identify and solve for any system process needs, supporting West Virginia's goals to enhance care coordination and reduce fragmentation. The SOC administrators in West Virginia will engage and participate in cross-sector collaboration to address community conditions where our members, providers, and community stakeholders work and live. By employing SOC administrators, Aetna health plans take a full view of the challenges associated with delivering high-quality care, necessitating cross-sector collaboration, and communicating with and identifying solutions with other Aetna internal departments including Care Connections.

[MS009] Screening, Stratification, Assessments, and ID of Triggers for Completion of a Comprehensive Assessment

Aetna has a detailed, proven process for screening, stratification, and identifying triggers, or items that prompt us to complete comprehensive assessments. Our process includes facilitating timely screening based on the unique needs of West Virginians that drives further assessment and risk stratification, allowing for consistency in matching each member to the right level of support and programming based on their unique needs. This includes specialized processes for identification of CM for members in specialty populations including pregnancy/maternal, pregnancy with SUDs, chronic conditions, members with disabilities, specialized pediatric and/or adolescent programs for WVCHIP members, members with complex or serious medical conditions, and children with special health care needs.

Our initial screening and engagement activities are designed to understand each unique member in the context of their lives and determine appropriate programming. Once a member is

identified as enrolled with Aetna, we initiate our automated outbound screening process that includes a telephonic HRQ. The HRQ is an automated survey that allows members to respond to brief questions about factors that impact their access to care or engagement in care using telephone prompts. The outbound system continues member outreach if the HRQ is not completed in the member's first 90 days. The HRQ is available in English and Spanish and can also be completed in-person, via printed, web-based forms, and if necessary, in alternate formats such as Braille. To maximize the number of members completing the initial screening process, we use multiple telephonic and written engagement strategies. We make five attempts to contact the member or guardian by phone, each occurring on different days and times to improve the likelihood of contact. Members can also complete the HRQ via the member portal or on the smartphone mobile application. **[MS006]**

If a member or guardian identifies a positive screen during our automated process, they are immediately warm transferred to a CM associate who completes a more detailed, health questionnaire which includes but is not limited to the outreach questionnaire (ORQ). Once screened, members are stratified into one of three levels of CM based on the complexity of need. The three levels of CM include the following: Tier 1, population health care coordination; Tier 2, supportive CM; and Tier 3, intensive CM. Members identified as needing supportive or intensive CM are assigned a dedicated care manager. Members identified for the population health level of intervention can access a CM associate whenever needed for ongoing, continuous support. **[MS007]**

Screenings, questionnaires, and assessments are completed based on each member's individual circumstances and the complexity of their unique needs. Aetna offers a wide range of

tools and evidence-based, comprehensive assessments that can be utilized depending on variances in member risk levels. For example, a pregnant member who uses substances may present with risk factors such as exposure to trauma or mental illness. Care managers are fully trained on utilizing all Aetna assessments and facilitate completion of the appropriate assessments based on the member's circumstances; in this case, assessments for substance use and trauma may be completed for this member. Aetna assigns dedicated clinical care managers based on individual member needs and condition(s). If a member is diagnosed with a chronic condition and is stratified in Tier 3, intensive CM, that member is assigned to a specialized Care Connections program and is assigned a clinical care manager with the appropriate education, experience, and training for that condition. For example, a member diagnosed with diabetes is assigned a care manager who is a registered clinician with nursing expertise and participates in Aetna's Diabetes Management program, which provides support for understanding the health risks of diabetes and the benefits of adhering to blood glucose testing and preventive activities.

Clinical care managers complete initial assessments within 30 days of enrollment based on variances in risk level using various methods, including in-person visits, reviewing Aetna's electronic CM documentation system for a member's history and previous care, and gathering assessment and intervention information from providers and involved parties (e.g., family or caregivers). **[MS007]** Clinical care managers complete an initial, in-person visit and if necessary, additional in-person visits or follow-up telephone calls to complete the initial assessment. Care managers meet with members in their preferred locations, dates, and times. If the member is a child, care managers include parents and/or legal guardians to schedule

assessments and gather assessment information. Prior to completing the initial assessment, care managers review Aetna's electronic CM system, reviewing any documentation for previous care or member interaction with other departments, such as MS. Care managers secure signed releases of information from members for coordination of care with existing and previous providers. For example, if a member has an existing relationship with a specialist for hypertension, care managers contact the specialist and gather assessment and intervention information. That information is documented and added to Aetna's electronic CM system for seamless continuity of care. Care managers complete reassessments using the methods identified herein any time there is a significant change in a member's circumstances, as often as necessary, and at minimum, annually. For example, if a WVCHIP member is newly diagnosed with autism, the care coordinator reaches out to the member and family to reassess the member's clinical status, gathers information from parents and providers, and provides support and education to the parents.

Aetna completes risk stratification initially after assessments are completed, and on a monthly basis, assuring members are aligned with appropriate programs and services customized to their individual needs. Our proprietary and evidence-based electronic risk stratification platform is a tool using analytic methods honed for more than 10 years. Our electronic risk stratification platform contributes to member stratification using internally developed algorithms based on population data and clinical and informatics expertise. It includes census tract, ZIP code data, and SDOH at the population health level in its predictive modeling. Our electronic risk stratification platform, in conjunction with predictive modeling risk scores, emergency room (ER) risk scores, and inpatient risk scores, determine each member's risk level. This stratification,

combined with Aetna screenings, questionnaires, and assessments, concurrent review information from inpatient or residential stays, and other medical and pharmacy utilization data, are combined to create an overall score that aligns members to the appropriate intensity and tiered Care Connections program. Our electronic risk stratification platform's algorithm communicates with the electronic CM documentation system, notifying care managers immediately when a member's risk level changes, triggering further assessment or reassessment.

We identify triggers or items that prompt us toward comprehensive assessments, which support clinical care managers to complete additional, comprehensive assessments through our screening tools and questionnaires and through our monthly risk stratification. If a member identifies a positive screen on any screening or questionnaire, care managers are notified to perform additional, comprehensive assessments appropriate to the member or family's needs. Aetna utilizes a variety of evidence-based, comprehensive assessments for the assessment of mental/BH conditions, trauma, chronic conditions such as hypertension and asthma, and specialized circumstances such as assessments appropriate for children involved in the juvenile justice system. **[MS009]**

[MS011] Identifying Priorities and Preventing Duplication of Assessment Efforts Using PCP Data

Aetna's Care Connections staff outreach to our members' PCPs to identify priorities and prevent duplication of assessment efforts. For members enrolled in supportive or intensive CM programs, Care Connections staff contact members' current and former PCPs to gather assessment and treatment information prior to completing additional, comprehensive assessments. This information is incorporated into Aetna's electronic CM documentation

system. Assessment information is utilized to identify priorities and prevent duplication. Aetna also uses claims history and Healthcare Effectiveness Data and Information Set (HEDIS) data to prevent duplication. For example, if a member's claims history shows the member had a well-child visit and related immunization, that information is loaded into our electronic CM system. Aetna's electronic CM system includes Admission, Discharge, and Transfer (ADT) data from the West Virginia Health Information Network (WVHIN). Care Connections staff have access to view ADT data in the WVHIN prior to completing additional, comprehensive assessments. Aetna's in-network providers can view members' claims history in our secure provider portal. The claims history offers information on member assessments and interventions. **[MS011]**

[MS012] Management of Assessment for Difficult-to-Reach Members or Members who Refuse Assessments

Aetna uses multiple strategies to engage members who are difficult to reach or who refuse assessments, including making multiple, telephonic, and in-person outreach attempts and collaborating with our co-located Care Connections staff, CVS Health retail pharmacies, and stakeholder organizations to locate members. **[MS012]** Aetna has written policies that enforce and support completing multiple attempts to locate difficult-to-reach members. Care Connections staff initiate contact via the telephone at different times in the day to increase the likelihood of reaching a member. Care Connections staff engage our co-located staff, and local CHWs and/or schools, if applicable, when telephonic and in-person attempts are not successful.

The Aetna Medicaid organization has initiated innovative approaches with our CVS Health partner. In partnership with the Department, we will leverage this expertise in West Virginia to improve member engagement for difficult-to-reach members. Aetna Care Connections staff can access retail pharmacy contact information for our members through our **Engagement**

Dashboard. By integrating functional area data, we can increase member engagement opportunities with members who are CVS Health retail pharmacy customers. This integration supports our ability to outreach difficult-to-reach members or members who may benefit from Care Connections services. Our Engagement Dashboard provides member contact data from CVS Health retail pharmacies for Medicaid Care Connections staff to improve our chances of contacting unable-to-reach members. If a Care Connections staff successfully reaches a member, the contact information is added to our electronic CM system for future use. Additionally, we are evaluating opportunities for **In-Store Engagement Conversations,** which support the Department's goal for enhancing access to care and can improve our reach rate for difficult-to-reach members or members who refuse assessments. In-Store Engagement Conversations are a CVS Health retail pharmacy collaboration in which Aetna places a digital alert in the CVS Health system to alert the CVS Pharmacy staff that we are looking to engage a difficult-to-reach member. We improve engagement in CM by leveraging CVS Health Pharmacy in-person interactions and physical takeaway card to educate members on Aetna CM programs. The CVS Pharmacy staff documents interaction notes and the best day/time for the person to be reached which is sent back to the Aetna clinical documentation system. Clinical staff in the Care Connections department can use this information to complete outreach. Both CVS Health opportunities, in-store engagement conversations, and the Engagement Dashboard, improve our opportunity for clinical engagement and outreach to members.

Members can choose to opt out of programs including Care Connections, but we offer multiple avenues for opting in at later dates and can engage local CHWs to assist in connecting with members who may benefit from Care Connections services. The option to opt out can occur

during screening and is described in the welcome letter. During conversations with members and in our letters, we provide the toll-free contact number for our MS department and the Care Connections team for members who have opted out should they later decide to engage in services. Members who have opted out of our Care Connections program still receive educational newsletters twice per year and new member packets. Specialized mailings for pregnant women, wellness reminder mailings, and community outreach events are also available for members who have opted out of Care Connections. If a member who is assigned to a Care Connections program begins to demonstrate a pattern of disengagement from services, for example, missing multiple appointments or not attending their treatment planning meeting, we complete outbound calls to engage, listen, and discuss the importance of appointment attendance. We listen carefully, offering solutions should the member report barriers to attendance. MS representatives are trained on the benefits of Care Connections programs and capitalize on opportunities to educate our members during calls to the MS department. Whenever possible, representatives offer education and warm transfers to the Care Connections department for program enrollment and immediate scheduling of comprehensive assessments

Given the importance of care coordination and engaging members in appropriate care. Aetna utilizes population health strategies in alignment with **NCQA Population Health Management** standards that support engaging difficult-to-reach members and members who refuse or opt out but may benefit from services. This includes collaborating with local based CHWs in West Virginia communities who can engage members, identify risk, educate members about the benefits of Care Connections programs, and when necessary, offer a referral to immediately

enroll members in Care Connections programs. Additionally, Aetna has established an initial program launching in spring of 2020 with **Unite Us**, a program that offers technology to monitor and track completion of, community-based referrals. We have agreements with several CBOs that offer social services and support in local, West Virginia neighborhoods, addressing needs such as assistance with food, housing, and transportation. Staff who work at the CBOs will refer members using the Unite Us platform to identify the closest, viable resources to meet each person's needs. Once the person needing assistance has received assistance, the CBO staff will document the referral and that the referral was closed, creating a closed-loop tracking system that supports Aetna's ability to help our members achieve healthy outcomes.

[MS010] How Assessments are Used to Develop and Update Treatment Plans and Confirm Risk Stratification

Both initial and ongoing assessments guide treatment plan development and help identify each member's individual needs. Aetna's comprehensive assessments allow care managers to capture needs, preferences, barriers to health care, and SDOHs that impact access to care (e.g., lack of available transportation or housing instability), and detail about specific health care issues including chronic

Aetna uses assessments and reassessments to update and reprioritize treatment plan goals. For example, Sherry's (not her real name) treatment plan goal is learning ways to manage her condition after her stroke one step at a time. It is ranked as a high priority and is identified as the first goal. The barrier identified includes Sherry's lack of motivation. The interventions address the goal and barriers and include setting up BH counseling and for her clinical care manager to assist in identifying coping skills for depression and to send her new assessment information to her provider. Sherry's second treatment plan goal is to find community resources to meet her needs. It is ranked as a medium priority. The barrier is Sherry's finances and her functional impairment. The interventions address the goal and barriers and note that her clinical care manager will mail information to the transportation vendor for registration in the program and to enroll Sherry in Aetna's adult walking program, a value-added service. The treatment plan includes dates for the next treatment team meeting as well as target dates for goal achievement.

disease and mental health. Care managers, fully trained in cultural sensitivity, trauma-informed care, motivational interviewing, and MHFA, facilitate and guide information gathering during assessments that drive individualized treatment goals and action steps. Goals are specific, measurable, and time-bound, and include rankings to determine priorities. During treatment planning meetings and in collaboration with the member, providers, and other care team staff, the clinical care manager facilitates discussions based on assessment information to develop treatment plan interventions. Care managers, who are responsible for facilitating the intervention, document intervention timeframes for completion. Ongoing assessments can be utilized in the same way as initial assessments, offering opportunity to document and celebrate accomplished goals as well as update barriers to goal achievement and solutions to address barriers. If a member's health care or social needs change or a member demonstrates successful behaviors in self-managing their diabetes, care managers can facilitate discussion and reprioritizing goals based on the new assessment information. Assessment information confirms risk stratification and aligns members with the appropriate Care Connections program or other services appropriate to their needs. For example, this same member diagnosed with diabetes may have been enrolled in Tier 3, intensive CM, but after success in achieving treatment plan goals, they may be more appropriate for Tier 2, supportive CM. **[MS010]**

[MS013] Storing and Sharing Assessment Data with the Care Team

Aetna stores and shares assessment data, treatment plans, and other critical member information via secure processes using our electronic CM platform. Members, providers, stakeholders, and other involved care team parties have timely access to assessment and treatment plan information, assuring coordination of care. Our electronic CM platform currently includes ADT data from the existing WVHIN. We are continuing efforts for full integration of the

WVHIN into our platform. Integration of data systems offers timely sharing of information across multiple stakeholders, contributing to seamless continuity of care. For example, if a pregnant member uses the ER at a local hospital, care managers have read access to that information in our electronic CM platform via the WVHIN data feed. Clinical care managers can reach out to members, providers, and the treatment team to make certain timely reassessment and coordination of care and needs. **[MS013]**

[MS014] Sharing Assessment Data with Other Payers

Aetna has written policies that support transition of care for members including sharing assessment data with other payers, after securing member consent, to prevent duplication of assessment efforts. Our policies have protections in place to prevent data breaches and allow for the sharing of information. Care Connections staff must identify and confirm the providers and organizations supporting and funding all services for each member, as part of seamless transition of care. This includes but is not limited to other payers, BH payers, waiver programs, out-of-plan services, county and legal programs, and other agencies. Care Connections staff facilitate the transition of medical records including assessments, when applicable, initiate any service authorizations required for services, send service authorization letters as appropriate to the relevant providers, and initiate letters of agreement for non-participating providers, referencing those letters with waiver programs or out-of-plan services to help to ensure effective management of payer sources. **[MS014]**

[MS002] Leveraging Information Technology Solutions to Improve Access to Member Information

Aetna has demonstrated experience leveraging information technology (IT) solutions to improve access to member Information including integrating the Department's enrollment data, Aetna's

claim data, data from WVHIN, and West Virginia's electronic platform for our Specialized Managed Care Children and Youth program with our proprietary, evidence-based stratification tool. Our electronic CM platform currently includes ADT data from the WVHIN, and we continue efforts toward full integration which will allow us to readily identify members who may be eligible for enrollment into Care Connections and in need of a comprehensive assessment. Our integration extends its reach to members, providers, and stakeholders through use of our interactive voice recording when calling the MS department, BH Crisis line, or Health Information line, and the use of our secure member and provider portals and our smartphone mobile application. **[MS002]** Our CVS Health **engagement dashboard,** as described previously, interfaces with Aetna and provides member contact data from CVS Health retail pharmacies for Medicaid Care Connections staff to increase reach rate of unable-to-reach members. If a Care Connections staff successfully reaches a member, the demographic contact information is added to our electronic CM system for future use.

Cultural Competency

MS048 The Vendor should describe how they will foster cultural competency among staff.

Cultural competency and the reduction of health care disparities have been a part of Aetna's core values throughout our history and are key initiatives nationally for the Aetna Medicaid organization. We are committed to continuously increasing cultural awareness, supporting health literacy, and developing programs to reduce health care disparities and promote equity for every member regardless of race, ethnicity, gender, socioeconomic status, disability, or other needs. We translate these values to our local West Virginia communities by making certain we understand the needs of our members. We make sure our member feedback forums optimally

engage as many members as possible and use feedback to improve the member experience, design our programs, and customize provider and staff education.

Aetna's multicultural approach to health begins with a comprehensive definition of cultural competency that includes race, ethnicity, physical/mental abilities, and preferred language, yet expands to the impacts of SDOH such as poverty, health literacy, cultural beliefs, and gender. We recognize our members and providers represent a unique mountain culture and are in one of the most impoverished states in the nation—with vast differences in SDOH, disability, and health-related behaviors across service areas. Our Cultural Competency Plan (CCP) explores the differences of lifestyle caused by each of these factors and its impact on the quality and well-being of our members' health outcomes and their health care journey—**West Virginians serving West Virginians.**

We employ multiple strategies to make sure we promote culturally competent services, including having a comprehensive CCP program, hiring bilingual and multilingual staff, using a hands-on approach to community outreach, maintaining ongoing staff and provider training, and utilizing member and health education materials that reflect the needs of the population served. **[MS048]**

Cultural Competency Plan: Our CCP uses the national standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care as the framework for developing and implementing policies that govern our delivery of services. We are committed to meeting all 15 standards and develop our CCP in a way that supports the first Principle Standard—thus advancing

health equity and reduction of health disparities.[4] Our program includes comprehensive planning and training processes, and a full complement of culturally and linguistically responsive services intended to provide an understanding of and improved access to readily accessible, high-quality health care services. The program includes compliance, oversight of linguistic and translation services, and the promotion of cultural sensitivity, health literacy education practices, and adherence to state and federal requirements. The CCP is subject to ongoing review by internal and external resources. We conduct a comprehensive evaluation that includes information from member complaints, satisfaction surveys, and Member Advisory Committee (MAC) meetings to measure improvement in knowledge and practice. We identify strengths and weaknesses, enabling us to develop a plan for improvement.

Hiring bilingual staff and assuring interpreter and translation services: Our MS department has several representatives that are bilingual. **Our current department include staff who speak Spanish, Russian, Mandarin, Cantonese, and Haitian.** All representatives who are bilingual are certified through a language certification vendor as interpretive specialists. We adhere and hire according to Department standards that recognize when non-English languages reach a high percent, and we hire accordingly. In addition, health plan representatives are fully trained in utilizing and accessing oral interpretation and written translation services for all prevalent, non-English languages, American Sign Language, and TTY/TDD for members who are deaf or hard of hearing. **[MS042]**

[4] Aetna's CCP is compliant with the following federal and State regulations: Title VI of the Civil Rights Act guidelines and the provision of auxiliary aids and services, in compliance with the Americans with Disabilities Act; and the Title III Department of Justice Regulation 28 C.F.R. & 36.303, 42 C.F.R. & 438.10(h). Aetna promotes national standards for CLAS in Health and Health Care developed and promoted by the United States Department of Health and Human Resources Office of Minority Health (HHS-OMH).

Community outreach: Our Community Outreach team takes a hands-on approach to understanding how Aetna can promote access to care and member engagement in their health care journey. Our MS staff and other health plan representatives often attend community events in collaboration with our Community Outreach team, promoting our member experience and community engagement. We attend local community and health and wellness events that support their needs. For example, our West Virginia Community Outreach team has a **longstanding relationship with the Family Resource Center at Marcum Terrace**, an area of West Virginia where residents and our members struggle with the effects of poverty and the prevalence of opioid use. Community Outreach staff participate in live events in collaboration with local food banks offering support for food insecurity and health education that promotes healthy behaviors and preventive care such as well-child visits. **Figure 6.5.1-5** illustrates our Community Outreach Director, James Smallridge, and our Chief Executive Officer, Todd White, sponsoring $3,000 to Facing Hunger Food Bank for additional backpack supplies. When necessary, staff assist members to enroll in Care Connections programs or value-added services, assuring linkage to care. Feedback gathered is forwarded to our Aetna teams and providers for consideration in training, operational, and programmatic practices.



Figure 6.5.1-5: Aetna's Donation to Facing Hunger Food Bank
Aetna Better Health of West Virginia recently made a $3,000 donation to the Facing Hunger Food Bank to help with funding for additional backpack program supplies.

Staff education and training: We underscore the relationship between cultural competency and health literacy through our initial and ongoing trainings that focus on cultural diversity, health care equity, disparities, literacy, and regulatory requirements. We review the reasons for health care disparities across populations such as low literacy, language differences, and member mistrust. Our training curriculum includes required cultural competency classes, mandatory quarterly trainings, federal CLAS standards, unique needs of special populations, SDOH and their impact on accessing care, and vignettes and scenario-based training created from actual telephone calls based on the needs of our West Virginia members. We train all member-facing health plan staff on **MHFA, trauma-informed care, person-centered training, and understanding the SDOH.** Managers promote ongoing education by facilitating discussions in staff meetings on cultural competence on a quarterly basis at our local town hall meetings for all health plan employees. As part of our ongoing commitment to culturally competent employee education, health plan staff have access to our online no-cost training system which offers a robust library of health care, cultural competency, and managed care topics. Staff is given the opportunity to attend conferences and are

Our quarterly cultural competency trainings reflect Aetna's ongoing commitment to increase staff cultural and linguistic competency through learning opportunities. Managers and directors are provided with talking points intended to help guide meaningful discussions and learning. For example, our first quarter 2020 training topic is, "A Framework for Understanding: Supporting a Culture of Inclusion," focusing on inclusion for all cultures, differences, and persons regardless of ability. The training includes an outline for helping each staff take inventory of the current state of practice within the health plan. Staff complete assessments that provide opportunity for reflection and highlight strengths and areas for improvement. Another topic asks staff to reflect on how we build cultural competency through governance and policies, how we implement best practices that improve service delivery, and how we adopt strategies into our day-to-day operations.

encouraged to attend conferences related to our members needs such as understanding evidence-based practices for opioid treatment.

Customized educational and member materials: Aetna is compliant with federal and State regulations and the Model Purchase of Service Provider Agreement for State Fiscal Year 2020 requirements assuring member rights to materials in their prevalent language, assistance if a member has LEP or limited reading skills **[MS032]**, or needs the use of auxiliary aids **[MS041]** and services, and adheres to all marketing regulations and requirements, respectively. Our educational and member materials include plain language at the sixth-grade reading level and include photos representative of the cultural, language, and unique needs of the populations we serve.

We are West Virginians serving West Virginians—we understand the regional health care disparities that exist in West Virginia and we employ multiple interventions to work with our providers on addressing health care disparities in our communities. This includes having an established Health Care Equity (HCE) program, population health initiatives, offering provider education and support, having integrated, experienced, locally based Care Connections teams, assuring a comprehensive network of providers, and facilitating MAC meetings that incorporate feedback into the continued development of our programs.

HCE program: Our West Virginia HCE program focuses on the three pillars of health care equity: cultural competency training and practice, health literacy, and reduction of health care disparities. Our HCE program provides a continuum of learning and action that includes ongoing education for providers and opportunities for providers and community organizations to collaborate in a way that aligns action to reduce health care disparities for our members. Aetna

attends monthly collaborative meetings with other Aetna Medicaid organization health plans that support health equity initiatives, using best practices identified on a national level, bringing those to our local West Virginia communities and providers. We provide our West Virginia Medical Management team **monthly reports that outline data describing individual member health care in effort to reduce disparities.** This report is used to address both individual member-level barriers to care and inform our policies, strategies, and system design. An example of the data available on our monthly report includes member name, ZIP code, dates screenings and assessments were completed, race, ethnicity, gender, sexual orientation, source of income, and employment. It also includes SDOH that can negatively impact each member's access to care such as food security, reliable transportation, exposure to violence, and housing stability. We include whether members have LEP, a history of incarceration or institutionalization, dependable supports systems, and religious preferences. We include their primary method for accessing care (e.g., ER or urgent care, travel distance to their PCP, medication adherence, their ability to understand health instructions, and need for dental services). Clinical care managers can use this report to aid in removing barriers identified in the treatment plan. An example of how we inform strategies includes the design of our integrated Care Connections approach. We analyze the data and use our learnings to design the West Virginia Care Connections program. This includes offering regional teams who are experts in issues that impact our members, such as maternal and pregnancy care and substance use disorders and offering teams that are co-located at provider offices.

Population health initiatives: West Virginia members suffer from health disparities such as food insecurity, high rates of obesity, chronic conditions, tobacco use, and substance and opioid

use. Aetna utilizes population health strategies in alignment with NCQA Population Health Management that support ongoing risk stratification and engaging all members in healthy behaviors and appropriate services in effort to reduce health care disparities. Additionally, Aetna has established an initial program to launch in the spring of 2020 with **Unite Us,** a program that offers technology to monitor and track closed-loop, community-based referrals. We have agreements with Unite Us and several CBOs that offer social services and support in local, West Virginia neighborhoods, addressing needs such as assistance with food, housing, and transportation. Staff who work at the CBOs will refer members using the Unite Us technology to identify the closest viable resources to meet each person's needs. Once the person in need of assistance has received it, the CBO staff will document the referral and that it was "closed," thus demonstrating a closed-loop tracking system that supports Aetna's ability to help our members achieve healthy outcomes.

Provider education and support: We offer education to a network of approximately 11,000 providers through provider notices, website articles, discussions during provider meetings, and our provider manual. Our Aetna website includes a dedicated page for provider education on cultural competency and health literacy. As part of our CCP, we encourage our providers to access "A Physician's Guide to Culturally Competent Care"

Aetna's innovative approach to creating an organizational trauma-informed care transformation including providing education and training to staff and providers leads the way across the nation on serving members who have experienced trauma. Through our collaboration with the National Council on BH, the West Virginia team was one of the first plans in the county trained in advanced coursework on trauma-informed care. Aetna is conducting a live training for over 100 providers on trauma-informed care and SDOH on February 12-13, 2020, which will be recorded and available via Aetna's website.

from the Office of Minority Health. This program is available via a link on our website and is endorsed by the American Medical

Association, the American Academy of Family Physicians, and the American College of Physicians, which provides up to nine hours of continuing education credits at no cost. We also offer a no-cost online course in health literacy called "Effective Communication Tools for Healthcare Professionals." This is an online, go-at-your-own pace training supported by the United States Department of Health and Human Resources that has helped more than 4000 health care professionals improve patient-provider communication. We develop and facilitate live training that targets the needs of our West Virginia members. We monitor provider performance using feedback from our members and satisfaction surveys. We subcontract for language interpreter services, available to all in-network providers for verbal interpretation and written translation, which provides 24/7/365 interpretation services for more than 240 languages, and we make certain there is access to TTY/TDD services for members who are deaf or hard of hearing.

Integrated, experienced, local Care Connections teams: Aetna's integrated, experienced locally based Care Connections care managers are integral to our efforts to reduce health disparities by addressing the whole person— medical, mental/behavioral, and social needs. If a member's health is impacted negatively by lack of stable housing or transportation, Care Connections staff address those as part of an integrated treatment plan. Clinical care managers connect new providers to Aetna's comprehensive network of providers. If a care manager learns of a new specialty provider who specializes in serving members with disabilities through use of a

single-case agreement, the provider information is forwarded to the Provider Relations team for outreach to become an in-network provider.

A comprehensive network of providers: Our comprehensive network of approximately 11,000 providers supporting the geographic, cultural, and linguistic needs of our members includes PCPs, specialists, pediatric providers and specialists, geriatric providers and specialists, family practice, children's mental/BH, addictions medicine, and many others. We make sure members have geographic access, services in prevalent language or use of 24/7/365 interpreter services, and access to significant traditional and specialty providers.

One of our challenges has been improving attendance to our quarterly MAC meetings. For our second-quarter meeting, held June 28, 2019, we designed the meeting to be a kid-friendly event since the children were out of school for the summer. We reserved a picnic area at a local water park and members and their children were invited to enjoy lunch. During our meeting with the parents, children were supervised and enjoyed the pool while the adult members attended the meeting. This format allowed Aetna to gather critical feedback and it provided a healthy outdoor activity that promoted wellness for our members and their children. We had seven members attend, which was the best attendance we have had since the inception of our MAC meetings.

MACs: We listen. We learn. We change. Aetna staff assesses members' level of health literacy and identify ways in which their culture may influence preferences or abilities. During our MAC meetings, we solicit feedback from members on ways to improve the delivery of our health care services. Feedback is utilized to design education materials, inform members, or train our internal Aetna staff. For example, we held a MAC at the **Family Resource Center in Marcum Terrace in fall of 2018** due to our long-standing relationship with members who use the Family Resource Center services. We routinely collect data about the impact of specific programs on West Virginia health care initiatives, which are shared with operational staff and are incorporated into our quality improvement program.

Health Education Programs

MS001	The Vendor should describe how they will collaborate with stakeholders to design materials that best meet the needs of the populations being served.
MS045	The Vendor should describe how they will administer a health education program for disease and injury prevention and identification.
MS046	The Vendor should describe its tobacco-cessation program.
MS047	The Vendor should describe how they will leverage community events/resources to help improve the health of its member population.

Aetna has demonstrated the breadth and depth of our experience and understanding of the needs of West Virginia managed care programs throughout our 23 years serving the Department, our collaborative relationships, and our health education materials. Our mission is to continuously deepen our presence in the communities we serve, with a special focus on understanding the unique needs of our members and potential new members and programs to improve quality of care and health outcomes. We achieve this through locally designed and targeted efforts that maximize investments, form long-term relationships, and leverage the power of employee giving and volunteerism. Our dedication to be a collaborative and innovative partner to the Department, members, providers, CBOs, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier West Virginia.

Aetna invests in the communities we serve. Our longstanding presence across West Virginia heightens our awareness to factors such as poverty that impacts local communities. We learn about and utilize community strengths to address those factors. Being in and of this region affords our members the opportunity to rely on the trust we have built up with members and their families to enhance their well-being and overall health outcomes. We are committed to assisting all West Virginia families struggling with poverty, addiction, limited resources and access, and other SDOH barriers such as transportation access. Our work with West Virginia families through our school-based relationships, Head Start, and food banks are excellent examples of

how Aetna draws on our lived experience within our own communities to meet the needs we see our neighbors struggling with. These are our communities, and we are their neighbors and service providers **dedicated to focused, tailored, and data-driven evidence-based health education programs to best meet their needs**.

[MS045] Administration of Health Education and Disease and Injury Prevention Programs

West Virginia ranks higher than the national average for deaths due to an injury. From 2001 to 2015, there was an average of 103.29 deaths due to injury per 100,000 compared to 62 per 100,000 nationally.[5] West Virginia also ranks higher in adult smoking at 23.43 percent than the national average of 18 percent.[6] Aetna has proven experience and an ongoing commitment of community involvement in the administration of health education and disease and injury prevention programs. Aetna's approach to administering an effective health education program that promotes prevention, supports member engagement in wellness activities, and positively impacts the likelihood of each member achieving meaningful, quality-driven health outcomes includes the following:

An Aetna Care Connections team was trained on infant safe sleeping practices and utilizes this knowledge to educate pregnant members enrolled in our Care Connections program. Additionally, our Community Outreach team has provided 500 families with health education and almost 400 families with portable cribettes, making a positive impact toward member awareness and safety about Sudden Infant Death Syndrome.

- A strong commitment locally via a **dedicated, West Virginia-based Community Outreach** team who understands the unique needs of our members and who live, work, and play in the communities we serve; who acts as an extension of our MS department; and whose outreach is informed by successes serving members with similar issues from our national Aetna Medicaid population health strategy and CVS Health experience and expertise

[5] County Health Rankings and Roadmaps, "2017 County Health Rankings Key Findings Report," County Health Rankings and Roadmaps; accessed January 2020; www.counthealthrankings.org/reports/2017-county-health-rankings-key-findings-report, accessed January 2020.
[6] Ibid.

- Fully trained Care Connections and MS staff who promote health education and prevention in member-facing interactions
- Frequent locally targeted community outreach and involvement at events and health fairs in partnership with the Department and in collaboration with stakeholders, schools, and CBOs
- Promotion of preventive health screenings, education, and events such as our **wellness events and mobile prevention screening programs**
- Informative member newsletters, health assessments, and self-management tools on our Aetna website such as weight management and **MyActiveHealth,** a tool that promotes completing and tracking healthy activities
- CVS Health partnership, Aetna Medicaid National Advisory Council, and Medicaid population health program inform our member education strategy
- Quick access to community-based resources nearest our members by calling our MS line; MS representatives have access to local resource guides including online resources that offer search by need and ZIP code or neighborhood
- **24/7/365 Audio Health Library:** Members can access more than 300 health, wellness, disease, and medical test audio recordings about various preventive and health education topics by calling our 24/7/365 Health Information line and following the prompts in the integrated voice recording. Each topic begins with a general description of the condition and provides causes, symptoms, diagnosis, and treatment. Examples of topics available include asthma, high blood pressure, alcohol and drug issues, assistance on how to quit smoking, pregnancy, preventive care, and many others. Members are empowered to make the best decisions for their health-related matters. **[MS045]**
- VAS customized to meet the needs of our West Virginia members and that promote prevention and engagement in health-related activities. Our VAS that specifically promote prevention and engagement in health-related activities are illustrated in **Table 6.5.1-1.** Our MS and Care Connections staff are fully trained to provide health education around VAS.

In 2019, CVS Pharmacy stores raised money in support of prevention and education efforts for various diseases, many of which impact the populations we serve and intend to serve. Donations included the following:

- **$22,418** in support of the American Heart Association
- **$18,780** in support of the American Lung Association
- **$20,607** in support of the American Cancer Society
- **$26,745** in support of the Alzheimer's Association

Table 6.5.1-1: Aetna VAS that Promote Healthy Behaviors

Type of Service	Value-added Service	Brief Description
Oral Health/Dental	Children's Dental Services	Based on HEDIS measures, parents are incentivized to schedule and attend a dental appointment for children age 2 to 3.

Type of Service	Value-added Service	Brief Description
	Dental Incentive for Members with Diabetes	Designed in collaboration with the West Virginia University dental school, members diagnosed with type two diabetes receive no-cost, routine dental care, tools that support healthy behaviors such as attendance at diabetes education classes, a journal, and dental hygiene kit, and incentives for completing critical HbA1c testing.
	Pregnancy Dental Care	As part of our Healthy Pregnancies, Heathy Babies program, we offer two preventive dental visits to members who are pregnant.
Maternal and Infant/Child Health and Safety	Healthy Pregnancies, Healthy Babies	Members participate in our text messaging campaign, receive two preventive dental visits, and a gift card for baby supplies. Members who complete the program receive a portable crib after successfully attending six prenatal visits. **Since 2016, Aetna has distributed 1,321 cribettes to pregnant and new moms participating in our program.**
	Moms and Babies	Targeted to pregnant women who struggle with substance use during pregnancy, members receive health education, support locating treatment, and upon successful completion of the program, a cribette.
	Keep Kids Safe Opioid Lockbox	Members prescribed opioid medications and have children receive an opioid lockbox offering a safe way to store medications away from children.
Chronic Disease Prevention and Management	Congestive Heart Failure Toolkit	Our toolkit includes weight management health education, a digital weight scale, and weight management diary.
Healthy Lifestyles	Ted E. Bear, M.D.[SM] Cub Club	Children age 13 and under receive health education and encouragement to complete a healthy task such as teeth brushing or exercise, and once completed, a reward such as a teeth-brushing kit or a sports ball.
	Good Health Practices	Members receive a gift card for scheduling and attending well woman, well-child (ages 12 to 18), and immunization appointments.
	ATV Safety Class Reward	We encourage our members to get active and be safe by completing a qualified ATV safety course and subsequent gift card as a reward.
	Back-to-nature Flu Shot	Adults age 18 and older receive a gift card toward the cost of an annual combination of a hunting/fishing license for completing their annual flu shot.

Type of Service	Value-added Service	Brief Description
	Adult Walking Program	Offers members a pedometer and tools to track their total daily steps.

As an element of Aetna's approach to administering an effective health education program, member health education is driven by the trends and needs of our local West Virginia communities. We use the feedback from our MAC, utilization and CM trends, and the national expertise from our Medicaid program, etc., to inform the development of member education materials. As an example, **Figure 6.5.1-6** illustrates our educational material targeting pregnant members to engage in our health education programs.

[MS047] Leveraging Community Events to Improve Population Health

Aetna's Quality Management, MS, and Community Outreach teams frequently participate in and leverage community events and resources to improve the health of our member population. We participate in a variety of community events and health fairs including events that address prevention and wellness. The following narrative describes our wellness events with providers aid in scheduling and attending preventive health appointments, mobile medical and dental screening services in remote areas, health education and outreach for opioid use disorders, and our **HealthTag™** and **Unite Us** programs. **[MS047]**



Figure 6.5.1-6: Aetna's Healthy Pregnancies, Healthy Babies
Aetna's population health program, Healthy Pregnancies, Healthy Babies, offers health education that supports healthy delivery of babies for our pregnant members.

Aetna's QM, Care Connections, and MS departments collaborate with local providers to facilitate wellness events that promote health education and support scheduling critical preventive health care appointments for adult and child physical and dental health care services. Our goal is to provide health education that promotes scheduling of preventive health care appointments and increases the number of members attending those appointments. We determine when and where to schedule based on evaluation of our HEDIS scores. Our QM staff evaluate regional HEDIS measures and pull reports on members in that region who have not

attended a preventive health care appointment. We identify our local, in-network providers in that region and collaboratively plan and schedule a wellness event that includes health education, appointment assistance, and if necessary, enrollment into Care Connections services. Once a date and time are determined, our health plan representatives or other internal staff complete outbound calls to identified members, educating about our local, no-cost event and the benefits of completing preventive health care appointments. Representatives help with appointment scheduling over the telephone and help to ensure members have necessary contact information and directions to the event. An Aetna representative completes an outbound reminder call a few days before the event, encouraging participation. Quality Management, Care Connections, and MS staff volunteer to participate at events, offering in-person opportunities to engage and educate our members about their health care and the importance of prevention. Care Connections staff are available to answer questions about Care Connections programs and enroll members immediately into relevant programs.

We currently offer the following event types:

- **Well child:** Children up to age 18 can obtain a well child exam
- **Children's dental:** Children up to age 20 can obtain a dental exam with a licensed practitioner
- **Well woman:** Adult women ages 21 to 64 can obtain a well woman exam that includes a Pap test and/or mammogram
- **Diabetes:** Members with diabetes can obtain a diabetic well exam that includes an HbA1c blood test, urine screening for nephropathy, blood pressure check, and/or a diabetic eye exam to screen for retinopathy

In 2018 and 2019, our Aetna team facilitated wellness events in Kanawha, Boone, Cabell, Jackson, Clay, Wayne, Logan, and Upshur counties.

Aetna held 13 events in 2018—4 well woman, 4 well child, and 5 diabetes— and 25 events in 2019—10 well child, 6 children's dental, 5 well woman, 1 flu prevention, and 3 diabetes. **We have positively impacted our members attendance at critical wellness and preventive**

appointments in 2018 and with an increase in 2019. In 2018, 56 percent of members we scheduled attended their appointments, and in 2019, 68 percent of members we scheduled attended their appointments.

We understand that West Virginia's mountain culture and geography can present a distinct access to care barrier for our members who live in remote mountain regions. To best serve remote mountain members, especially members without access to telephone or internet, Aetna has collaborated with a provider who has locations across the southern part of the state including Boone and Kanawha, to provide **mobile medical and dental screening services.** This collaboration includes offering physical health and dental services via mobile van units that will offer services such as preventive well woman and well child visits as well as dental screenings. Offering these critical preventive services allows us to better serve members in need, especially members of well woman and well child preventive exams as well as dental screenings for all Medicaid and WVCHIP populations served in this RFP.

West Virginia is severely impacted by the negative effects of opioid use disorders. Numerous indicators underscore the severity of these issues in West Virginia. According to the National Institute on Drug Abuse West Virginia Opioid Summary,[7] West Virginia had the highest age-adjusted rate of drug overdose deaths involving opioids in 2017; it was double the rate in 2010 and threefold higher than the national rate of 14.6 deaths per 100,000 persons. Additionally, the sharpest increase in opioid-involved overdose deaths was seen in cases involving synthetic opioids other than methadone (mainly fentanyl): a rise from 122 deaths in 2014 to 618 deaths in

[7] National Institute on Drug Abuse (NIDA) West Virginia Opioid Summary; Last Updated March 2019: accessed Jan 2020; https://www.drugabuse.gov/opioid-summaries-by-state/west-virginia-opioid-summary.

2017. In addition, West Virginia providers wrote 81.3 opioid prescriptions for every 100 persons compared to the average U.S. rate of 58.7 prescriptions in 2017. The prevalence of opioid misuse is reflected in the needs of the members we serve including members and members' parents who struggle with addiction and struggle to maintain social needs (e.g., food security or stable housing) due to addiction. Our Community Outreach team, informed by our national expertise on opioid prevention, intervention, and treatment, participates frequently in community events that support health education on opioid misuse. Our health education materials are targeted to the needs of local West Virginians and offered as takeaways at community events and are available on our website. **Figure 6.5.1-7** illustrates Aetna's collaboration with our community stakeholders and providers on **appropriate, effective care for our pregnant members who struggle with opioid use.** It illustrates and highlights how we support success in recovery and offers important health education about opioid treatment.



Figure 6.5.1-7: Aetna's Educational Brochure for Pregnant Members In Need of Opioid Treatment
Aetna offers customized health education materials targeting critical needs for our valued West Virginia members.

In collaboration with our CVS Health retail pharmacies, Aetna creates **HealthTag campaigns** that support the Department's goal for enhancing access to quality-driven care. HealthTags are messages printed on a member's prescription bag that offer health education. For more complex communications, Aetna can flag the member prompting pharmacy staff to engage them in a focused conversation when they are picking up a prescription. HealthTag messages and pharmacy staff discussions are related to the member's medication or a gap in care such as getting preventive care or getting a flu shot. We will leverage this expertise in partnership with the Department, offering an enhanced capability to reach, engage, and education our valued West Virginia members.

Aetna has established an initial program launching in spring 2020 with **Unite Us,** a program that offers technology to monitor and track closed-loop, community-based referrals. We have agreements with several CBOs that offer social services and support in local West Virginia neighborhoods, addressing needs such as assistance with food, housing, and transportation. Staff who work at the CBOs will refer members using the Unite Us technology to identify the closest viable resources to meet each person's needs. Once the person receives assistance, the CBO staff will document the referral and that the referral was 'closed,' thus creating a closed-loop tracking system that supports Aetna's ability to help our members achieve healthy outcomes.

[MS001] Collaboration with Stakeholders to Design Materials

Our dedication to be a collaborative and innovative partner to the Department, providers, CBOs, and other stakeholders defines us as a loyal organization driving the mission to create a healthier West Virginia. Aetna's Community Outreach team is an extension of our exemplary MS. We collaboratively attend community events that promote health education and prevention

for our valued members. For example, Community Outreach and MS staff attend "Live on the Levy," local parades, and make hospital visitations to members over the holidays. Our West Virginia Community Outreach director, Jim Smallridge, who is a West Virginian native states, "We don't just service members when they call the health plan, **we live, work, and play in their communities and participate in events that support healthy behaviors whenever we can.**" This passion is promoted in our MS department as well. Kelley Mitchell, manager of the MS department, encourages her representatives to be there for our neighbors in times of need. For example, recently when West Virginia was plagued with severe floods, Ms. Mitchell made certain her MS team was informed and ready to provide the help needed and supportive resources when members called. Per Ms. Mitchell, "We are not just a voice on the phone."

Together, we listen, we support, we care.

Aetna's Community Outreach team, led by Mr. Smallridge who is a registered nurse, creates annual outreach plans designed to be hyperlocal, targets each of the state's regions, and adheres to our system of care process. As a trained nurse, Mr. Smallridge has a unique perspective and leadership skills with eight years' experience with Aetna to engage community resources to improve overall population health through community engagement. The plan informs how we develop member communication, materials, and engagement and its execution is carefully monitored by our Community Outreach and QM teams. Our member engagement is a grassroots effort and includes outreach to members in addition to our CBOs. Aetna utilizes CBO and member feedback from community events, our call centers, individual interactions, and our MAC when we develop member materials. We are honored to have close working

relationships with many CBOs, as we value our combined impact in the communities we serve, and we use information learned to inform our member communication and materials. **[MS001]**

Our Community Outreach team works collaboratively with the following West Virginia groups. The following collaborations inform the design of our health education program and educational materials:

- Behavioral Health Provider Association
- National Association of Social Workers-West Virginia Chapter
- Provider Response Organization for Addiction and Care Treatment
- West Virginia Primary Care Association
- West Virginia Hospital Association
- Healthy Kids Coalition
- School Based Health Assembly
- West Virginia Osteopathic Medical Association
- West Virginia Healthcare Association
- West Virginia Board of Medicine
- West Virginia State Medical Association
- West Virginia Partners in Health
- American Cancer Society
- Mountaineer and Facing Hunger Food Banks
- Mountains of Health
- United Way of West Virginia

The Community Outreach team has **longstanding collaborative relationships** with advocates and stakeholders across West Virginia including government agencies such as West Virginia's Department of Education and school systems across the state. Mr. Smallridge makes certain there is ongoing collaboration with local **West Virginia schools**, continually understanding the needs and barriers to care for West Virginia children. The Community Outreach team has participated in multiple school-based events offering health education on preventive dental care. Parents and children who participate receive no-cost dental hygiene kits including toothbrushes and health education on the benefits of proper dental care. We work with School-Based Health Centers to stress the importance of preventative measures such as wellness exams, immunizations, and flu shots. The Community Development team has made presentations to numerous Title I parent meetings and PTA meetings around the state. We specifically target

schools with higher populations of Medicaid beneficiaries, such as Title I schools. We educate students as well as their teachers and parents on various health care topics, such as healthy eating and the importance of wellness exams and flu shots. **Figure 6.5.1-8** illustrates our Aetna Ted E. Bear, M.D., coloring book health education topics that promote healthy behaviors and is customized to children's reading levels in English and Spanish.

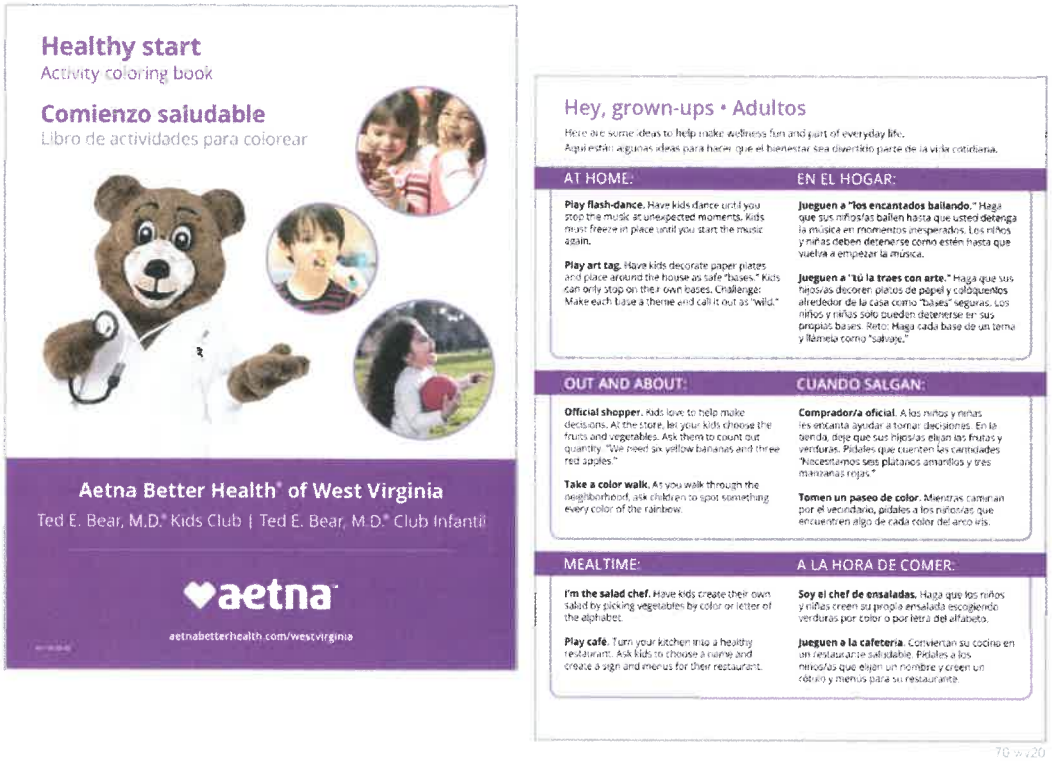


Figure 6.5.1-8: Aetna's Ted E. Bear, M.D. Coloring Activity Book
Aetna's Ted E. Bear, M.D., coloring activity book is designed especially for kids, at their level, and promotes healthy behaviors such as heathy eating, activity, and getting a flu shot.

Aetna works with school health clinics to provide screenings and wellness education during school-wide events. As a result, our established relationships support a seamless transition of care if the student should transfer to another school or school district. Additionally, we work

collaboratively with the following West Virginia organizations that serve members with special health care needs: schools, Family Resource Network, Adverse Childhood Experiences Coalition, Healthy Kids, libraries, after-school programs, Camp Appalachia, and the Affordable Healthcare "Medicaid Matters" group. We collaborate statewide with **West Virginia Head Start** to engage parents by connecting them with comprehensive and essential services that promote health, wellness, and education. Examples of topics addressed include the importance of wellness exams, healthy eating, and healthy activities.

Our health education, disease and injury prevention, and other member materials are designed in collaboration with our providers, professional organizations, and community organizations and address the unique needs of West Virginians in mind. The Community Outreach team offers health education on appropriate **utilization of the ER**, urgent care, and primary care services. Community events are designed using health care data from medical management services, targeting areas where education is needed about appropriate use of services. Our most recent collaboration, because of the impact of opioid misuse, is with **West Virginia Healthy Grand Families**. Based out of West Virginia University Institute, the Community Outreach team collaboratively designed a program to target grandparents raising children as a result of involvement in child welfare. Our health education materials will be customized to help grandparents understand how to care for children now in their custody and how to access needed care and support. As part of this program, Aetna will sponsor the Healthy Grand Families program, offering financial assistance for development of an eight-week training course.

Aetna complies with all marketing and member education requirements outlined in the Model Purchase of Service Provider Agreement for State Fiscal Year 2020 including strict compliance

to member materials requirements and 42 CRF 438.104 and Appendix D, BMS Marketing Policies. Our materials are prepared at no higher than a sixth-grade reading level, with easily readable typeface, frequent headings, and short, simple explanations of key concepts. We offer taglines advising members how to access member materials in other State-required prevalent languages. **[MS043]** We educate our members that member materials are available in paper form upon request within five business days. **[MS040]** Our website electronic information is prominent and readily accessible. We make auxiliary aids and services available as well as written translation in prevalent languages or as requested.

Aetna's strong commitment to addressing the opioid crisis in West Virginia is evident through our specialized Care Connections programs and services such as Lily's Place, serving pregnant and new mothers who need substance-use treatment, sponsorships, community outreach, and member health education materials. We collaborate with local providers, professional associations, and CBOs to make sure we stay on top of the latest trends, research, and needs to aid in developing our materials. **Figure 6.5.1-9** illustrates our brochure used at community events to engage and educate our members into appropriate programs and care.

As a second example more specific to our adult member needs, this member newsletter available on our website outlines diabetes education classes available to members at various locations throughout West Virginia including Mid-Ohio Valley Public Health, West Virginia University Medicine, Mon General Hospital, Potomac Valley Hospital, and United Hospital in Clarksburg. It also describes the benefits of wellness visits specifically for pregnant mothers and



Managing opioid medication

Meet Stephanie. Last month's car accident left her sore, so she's been steadily taking her opioid medicine to help manage the pain. As her prescription gets low, Stephanie is worrying about ongoing treatment. She wants to learn other ways to relieve her pain and safely manage opioids. Stephanie goes to see her doctor, who advises her on the following steps:

1. Find other solutions

Her primary care provider (PCP) talks about ways to help manage her pain without opioids, like exercise, over-the-counter drugs, and prescription anti-inflammatories.

2. Be ready with Narcan®

Stephanie's PCP also tells her about Narcan (naloxone) as a safety measure. Narcan is a drug used for people having an overdose. It can save lives.

3. Keep opioids away from others

Stephanie has two kids, ages 11 and 7. It's important to always keep medicine safe and away from others, especially young children.

4. Don't wait

Stephanie feels confident she can manage opioids. You can, too. We can help. Just call our Member Services number on the back of your ID card.

Aetna Better Health® of West Virginia

aetna™

aetnabetterhealth.com/westvirginia

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WV-19-02-01

Figure 6.5.1-9: Aetna's Smart and Safe Educational Tool for Managing Opioid Prescriptions

Aetna stays current on the latest trends, research, and needs for mitigating the opioid crisis, developing programs and health education materials customized to meet the needs of West Virginians.

teenagers, immunizations, and Early and Periodic Screening, Diagnostic and Treatment visits, specialized Care Connections programs for members with chronic diseases, tips for living with

asthma, what is available and how to access wellness tools on our secure member portal, and includes written taglines for members with disabilities and LEP, as illustrated in **Figure 6.5.1-10. [MS043]**



Diabetes help for you

Aetna Better Health of West Virginia is working with the following places to offer diabetes education classes for members at:

- Mid-Ohio Valley Public Health
- WVU Medicine
- Mon General Hospital
- Potomac Valley Hospital
- United Hospital in Clarksburg

Aetna Better Health of West Virginia members that have diabetes or pre-diabetes can attend a Diabetes Self-Management Program.

Our Case Management staff can help you sign up; if you need help with getting a ride we can provide you with help.

Once you complete the classes and obtain a follow-up A1C, you will be able to receive a $25 gift card.

Classes are available in the following counties:

- Calhoun
- Gilmer
- Mason
- Pleasants
- Ritchie
- Roane
- Jackson
- Wirt
- Wood
- Harrison
- Marion
- Monongalia
- Preston
- Randolph
- Taylor
- Upshur
- Wetzel
- Mineral
- Grant
- Hampshire

A little prevention goes a long way to Live Healthy

At Aetna Better Health, we're here to help our members live healthier lives. Three of the best ways to stay healthy are:

- A yearly wellness checkup with your doctor
- Being physically active
- Watching what you eat

Wellness visits can help you stay healthy. Even if you aren't sick, you need to see your doctor regularly. Along with a physical exam, your doctor may check your BMI. Your doctor will also give you great advice about healthy eating and exercise.

So take control and jump-start a healthier you. Make doctor visits part of your healthy routine. Call your doctor today and make an appointment for a wellness checkup. Sounds pretty doable, doesn't it?

Need help finding a doctor?
Just call Member Services at **1-888-348-2922**, TTY: **711**. Or log on to **www.aetnabetterhealth.com/westvirginia** to find a provider near you.

Aetna Better Health of West Virginia
500 Virginia St. East, Suite 400
Charleston, WV 25301

Aetna Better Health of WV Health Information Line

24-Hour Nurse Helpline

Do you have a medical question and don't know what to do? Call our 24-hour Nurse Helpline. Our Nurse Helpline can help answer specific health questions. You can also get advice on what to do when you need health care. The toll-free number for the Nurse Helpline is **1-855-200-5975**. You can also find the Nurse Helpline number on the back of your Aetna Better Health ID card.

Are you seeing a behavioral health provider or another specialist? It is important to let your PCP know. They will work together to provide the best possible care for you.

Let us help you

Sometimes, managing a chronic condition or multiple conditions is hard to do. We have special programs to help you with your medical, mental and social health care needs.

Do you have any of the following chronic conditions?

- Diabetes
- Asthma
- Depression
- Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure

We can help! You can participate in our Chronic Condition Management Program (Disease Management).

Our staff of trained Registered Nurses will call you. They can assist with teaching you how to help monitor and control your disease. We can also speak with your caregiver or support person with your permission.



We can help you get the tools you need to test your blood sugar. We can help you get tools to check your breathing and to weigh yourself daily if needed. We can also help you to access transportation to your medical appointments.

We can help you with healthy behaviors, such as eating better and quitting smoking. We can provide names of community resources and other resources available to you.

It is important that you communicate with your doctors and other healthcare staff. We can assist you in what questions to ask.

You will also be mailed information about your chronic conditions to help you understand your condition better.

To offer you support, your doctor, hospital discharge planner or caregiver may refer you to Care Management. However, don't wait for a referral if you need help. You can self-refer by calling us at **1-888-348-2922** and asking for Care Management.

Your Member Handbook will give you more information about our care management program. You can opt in or opt out of the program anytime. We're happy to help you if you have any questions. You can reach us at **1-888-348-2922**.

Is your child moving from child to adult care? We have trained professionals on staff to help you with this. We'll work with you to help get the right care for your child's special needs.

Living with asthma

Aetna Better Health of West Virginia wants to work with you to be healthy. We have nurse case managers who can assist you. We can help to improve your overall health. We will work with you to understand living with asthma. We will work with you to understand:

- An Asthma Action Plan to help you manage your asthma
- Your medications
- How to decrease your emergency room visits for asthma
- How to improve your overall wellness and better control of asthma
- How to decrease or stop the use of tobacco through smoking cessation programs

Call us at **1-888-348-2922** for more information on a healthier you.

An easy-to-use wellness tool for a healthier you

Our updated secure member website is your go-to resource to manage your plan—and your health. It will help you use your Aetna Better Health benefits and services so you can get and stay healthy. You can:

Access health plan details—change your doctor, find forms or request member ID cards.

Get personalized health information—answer questions about your health. Get the tips and tools you'll need to meet your health goals like quitting smoking and weight management.

Research prescription drugs—find a pharmacy, see how much a drug costs or ask for a drug not covered by your plan.

Get instant access to claims details—see the status of your claim from start to finish.

Find support—get in touch with a nurse. Or learn more about disease management and wellness programs that will help you stay on track with goals.



Visit **www.aetnabetterhealth.com/westvirginia** for the updated pharmacy formulary and latest Member Handbook.

Sign up today. It's easy. To set up your account or to learn more about these tools, you can visit **www.aetnabetterhealth.com/westvirginia**. Just click on the "Member Portal" quick link on the left side of the "For Members" page. And when you're ready to sign up, just select the "Register or Log In" link from the Portal page.

Keep in mind, you'll need your member ID and a current email address to create an account.

We're always here to help. For help getting started or to sign up over the phone, just call Member Services at **1-888-348-2922**, TTY: **711**.

The power of prevention: EPSDT visits help keep your kids healthy

What's the best way to fight diseases? Stop them from ever happening. Or start treating them early, before they become more serious. That's called preventive medicine. That's why your EPSDT visits are so important.

EPSDT stands for Early and Periodic Screening, Diagnosis, and Treatment. The visits are also called well-child visits. Your child sees the doctor when he or she is feeling well. All children under age 21 get a full exam. The doctor may give shots that help your child stay well.

Your EPSDT schedule depends on the age of the child. Children under age 2 go every few months. Older kids go every year. The visit is covered by your insurance. To find out if your child is due for an EPSDT visit, call your doctor.

A healthy start with the right shots

Getting your kids their shots is one of the most important things you can do as a parent. A record number of kids are getting the shots they need to stay healthy. That's great news!

The benefits of these shots last a lifetime. Your kids will never have to worry about the diseases that harm or kill many children in other countries. The shots your kids get are safe. They work very well. They almost never cause any reaction or have any serious side effects.

Your kids should have most of the shots they need by age 2. Older kids need booster shots now and then. Your doctor's office will know which shots your kids have had, and which they need.

Be sure you are up-to-date with your child's vaccination schedule. Call your doctor to make any appointments you need for these disease-fighting shots.

Figure 6.5.1-10: Aetna's Spring 2019 Member Newsletter
Aetna provides health education designed to meet the needs of our valued West Virginia members.

[MS046] Tobacco Cessation Programs

Aetna's Care Connections team includes a CM staff who has completed the Tobacco Treatment Training Program certified by the Council for Tobacco Treatment Training Programs and serves as a resource on this topic for the Care Connections department.

According to America's Health Ranking by the United Health Foundation, West Virginia ranks as one of the states with the highest percent of tobacco using behaviors,[8] which is linked to a higher prevalence of chronic disease such as cancer, low birth weights, and early death. In addition to promoting the West Virginia Tobacco Cessation program, Aetna offers a tobacco cessation program that is available to all members who use tobacco or vape, offers customized support and care, and is based on proven evidence-based approaches to quitting.

In 2019, CVS Health and Aetna supported educational programs to create and distribute educational materials for middle and high school students on the risks of e-cigarette use. A $100,000 grant was given to the Society of Health and Physical Educators to help distribute educational games from the Yale Center for Health and Learning to schools across the country. The CVS Health Foundation offered $600,000 to support the American Academy of Family Physicians Foundation to support its efforts to address the rising emergence of Electronic Nicotine Delivery Systems. Additionally, the Aetna Foundation worked to enhance education and training for children's health care professionals.

By calling the MS or Care Connections department, any member who identifies as a user of tobacco through our HRQ screening, is offered immediate enrollment into our Care Connections program and assigned a dedicated staff member who refers and connects to tobacco cessation services and supports. Our program offers one-on-one coaching by certified counselors, access to online tools, various educational media such as articles and videos, self-management tools that support quitting, and promotion and use of the West Virginia QuitLine. **In 2019, 1,686 unique Aetna members participated in our Tobacco Cessation program.** All member-facing staff

[8] United Health Foundation, "America's Health Rankings: West Virginia," United Health Foundation: accessed January 2020; https://www.americashealthrankings.org/explore/annual/measure/healthstatus_disparity/state/West Virginia.

such as MS, Care Connections, and Community Outreach are trained on health education programs such as tobacco cessation and have easily accessible referral information available when needed. Assigned CM staff will arrange for services and supports depending on the member's individual needs. Our program is designed using proven, evidence-based methods that facilitate engagement, participation, and the likelihood of effective program outcomes. Aetna clinical care managers and care coordinators are equipped to educate members about the negative effects of tobacco and vaping use for our West Virginia members. For example, we identify pregnant members at-risk for conditions that could potentially harm the member or their baby and offer support such as use of our Tobacco Cessation program. **[MS046]**

Aetna will leverage our CVS Health partnership to bring additional tobacco cessation programs and educational materials to West Virginia. CVS Health offers additional educational and preventive services, including tobacco and vaping cessation programs, and local pharmacists who speak at community events and schools to educate on the negative consequences of tobacco and vaping use. **[MS046]**

Member Services Call Center

MS018	The Vendor should describe its warm transfer protocols for its member services, other internal departments, other entities, and subcontractors, as applicable.
MS019	The Vendor should describe how they will train member services representatives.
MS020	The Vendor should describe how they will ensure they are meeting customer use and report to the Department on customer service performance standards including, but not limited to, the following:
MS021	Member-to-representative ratios
MS022	Call answering time, with a minimum of 83% of calls answered in thirty (30) seconds
MS023	Call abandonment rate not to exceed five percent (5%)
MS024	Single contact resolution
MS025	Turn-around time for member requests

MS026 Remediation strategies for performance issues

Our MS call center staff provides our first opportunity for **exemplary member service** by representing Aetna's core values of **inspiration and integrity** (doing the right thing for the right reason), **excellence** (highest quality and value through simple, relevant solutions), and **caring** (respect through insight, understanding, and compassion). We demonstrate these values through accountability in our existing West Virginia Medicaid call center by assuring excellence in our hiring and staffing practices, our hours of operation, our telephone protocols, our staff training, and our telephone performance. We describe the RFP's MS specifications in detail throughout this call center section, but as examples of our demonstrated values and accountability, our West Virginia MS call center achieves the following:

- Superior service excellence to our existing West Virginia members as demonstrated by exceeding Department performance standards in the last two calendar years in our existing West Virginia Medicaid call center:
  - **In 2018, we answered 36,285 calls with an 88.35 percent call answering time and a 1.4 percent abandonment rate** (the State performance standards are 83 percent call answering time and less than 5 percent call abandonment rate) with nearly 100 percent of calls resolved during the initial call to MS
  - **In 2019, we answered 44,591 calls with a 91.25 percent call answering time and a 1.56 percent abandonment rate** (the State performance standards are 83 percent call answering time and less than 5 percent call abandonment rate) with nearly 100 percent of calls resolved during the initial call to MS.

> One of our valued members shared this information about a call to the MS department in January 2020: "Maddie was fantastic. I had a very positive experience in a very stressful time since my husband is dealing with a chronic disease. Thank you very much. We made an incredibly good choice in going with Aetna."

- Supporting the State's objective for enhanced coordination of care and access to services through our concierge model of MS support, offering immediate, direct linkage to care coordinators, clinicians with nursing and BH expertise, providers, and other medical and clinical staff for urgent clinical and crisis support
- Supporting the Department's objective for reduced fragmentation and seamless continuity of care by making certain our MS representatives are fully trained in topics customized toward the unique needs of West Virginia members eligible and enrolled in MHT, WVHB, and WVCHIP Medicaid services including but not limited to the following:
  - **MHFA**

  - **Trauma-informed care and West Virginia's trauma transformation learning collaborative**
  - The unique needs of West Virginia members eligible for MHT, WVHB, and WVCHIP Medicaid services
  - Access to immediate crisis and clinical support
  - Person- and family-centered approaches
  - Support and linkage to community resources that address issues which typically impact access to care such as food banks, transportation, housing support, and social support
- Augmenting our West Virginia call center with the around-the-clock availability that supports the Department's objective for seamless continuity of care through after-hours access to our fully trained, MS representatives in our 24/7/365, national MS department

We are compliant with the Model Service Provider Agreement for State Fiscal Year 2020 for assuring our call center is open for at least eight hours a day. West Virginia's local MS hotline is in **Charleston, West Virginia.** We currently operate via one toll-free number from 8:30 a.m. to 5 p.m. Eastern Time, Monday through Friday and on select State holidays. Our toll-free phone number can be found on each member's ID card, in our member handbook, on our website, and in our member welcome materials. Our members have seamless, 24/7/365 access to Member Services—available, reliable resources to meet West Virginia member needs. After normal business hours, we route MS calls to our national call center, a centralized call center in Phoenix, Arizona. The national team assumes the role of the West Virginia-based MS representatives after hours. In a seamless redirection of call routing with no interruption, members speak with a well-trained, specialized team that, to the member, would be no different than service provided during normal business hours. Our national MS staff are trained in West Virginia MHT, WVHB, and will be on WVCHIP program-specific covered services, State-specific regulations and policies, Department requirements, and have access to the same electronic tools used by the West Virginia-based MS team. **Members receive the same exemplary service with consistent messaging and information.** For calls requiring clinical support, the national MS representatives have access to the Health Information line and BH Crisis Services

hotline; the MS representative completes a warm transfer of the member so we can address their clinical issues.

[MS018] Warm Transfer Protocols for Member-facing Departments and Subcontractors

Our MS hotline call routing provides timely, accurate responses to member inquiries. Members use one telephone number to access our support. When they call the toll-free MS hotline, our interactive voice response (IVR) system routes them appropriately by allowing members to choose the department that best meets their needs. Members initially hear an interactive voice prompt welcoming them to Aetna and advising calls are recorded and monitored for quality assurance purposes. The remaining prompts are as follows:

- Press number one if you have a mental health need or are experiencing a crisis
- Press number two for eligibility and benefits information
- Press number three for member ID card or welcome packet
- Press number four if you would like to speak to the CM department
- Press number five if you would like to speak to a health care professional on the Health Information line
- Press number six for transportation
- Press number seven for more options such as updating personal information, reporting fraud and abuse, or requesting interpretation services

If a member selects number two for member ID card or welcome packet, our prompts offer additional options, categorizing calls by need such as medical, vision, dental, pharmacy, and mental health or substance abuse needs. Whenever necessary, members have the option to return to the main menu. Members who identify the need for interpreter services via our interactive voice prompt or identify a need for a non-English prevalent language during the call receive appropriate assistance through MS representatives who immediately engage our oral interpretation services. Members who are deaf or hard of hearing receive appropriate assistance through MS representatives who immediately engage our TTY/TDD.

Our telephone management system supports seamless transfer of calls (three-way and other conference call capabilities) between our MS department and all other internal departments including Care Connections team, our Member Advocate, Member G&A staff; we also warm transfer members to providers, subcontractors, the Department and other entities, and our BH Crisis Services and Health Information hotlines. MS representatives also use three-way conference calling functions when assisting members to schedule appointments, connect with community resource agencies such as food banks, or coordinating with other payers. MS representatives are trained on how to use the telephone management system and practice making three-way calls during new-hire orientation. The system supports three-way conference calling across all departments such as when hotline staff needs to consult with a member's care coordinator or member advocate. MS representatives complete a warm transfer when making three-way calls. **[MS018]** For example, once a representative properly identifies the member and their concerns, the representative will call the third party and introduce themselves and the member and provide a brief explanation of the reason for the call. Representatives will stay on the line with the member or caller until the reason for the call is fully addressed, assuring single-call resolution and that the member's needs are fully met. Our MS representatives always request a callback number in case of technical difficulty.

Our MS representatives have resources available and strive for **single-call resolution,** supported by our P&Ps. Representatives use three-way calling, warm transfer protocol, and call escalation procedures to support resolving each member's concern during the initial call. When a member calls, the representative gathers HIPAA personally

One of our valued members shared this information about a call to the MS department in January 2020: "The representative, Bob, I just spoke to was quite helpful, and provided everything I needed in one phone call. I really appreciate his customer service."

identifiable information including the member's name, ID number, if known, date of birth, and the reason for the call. If the representative is not able to resolve the member's concern, they escalate the call to a senior MS representative or supervisor by notifying them via instant message and completing a warm transfer including explaining to the member that they are seeking assistance to immediately resolve the concern. MS representatives are trained on techniques such as de-escalation, active listening, and showing empathy to aid in single-call resolution. **[MS018]**

If single-call resolution is not possible, Aetna's electronic call documentation system allows for effectively tracking and resolving concerns when follow-up calls are indicated. If a caller is inquiring about a previously reported concern, the MS representative reviews the call documentation, determines if they can resolve the issue, or escalates to a senior or supervisory MS staff. MS representatives review call documentation daily, assuring all member and caller follow-up needs are met. We track and monitor turnaround time for member requests closely. **[MS025]** The MS director evaluates reports to monitor timely resolution and to reassign open records or allocate additional resources, assuring all follow-up calls are completed. Our Aetna internal goal is to complete all calls not resolved in the first or initial call within 24 hours of that same initial call. What we have learned through analysis of calls that are not resolved on the initial call, is that most are members who require transfer to other departments such as to the Care Connections team. This trend informed new procedures, assuring continuity of care. Our MS supervisors follow up with care managers on all calls not resolved during the initial call, coordinating efforts to make sure there is timely response and issue resolution. Our call records indicate if an outbound call is needed to inform the member of the final resolution. MS staff complete outbound calls and close the call record when all follow-up is completed.

At Aetna, our **Common Purpose** comes to life through our ability to seamlessly link members and callers to other Aetna departments, crisis support, and community resources, aspiring to single-call resolution—addressing each member's needs the first time they call. **Figure 6.5.1-11** illustrates our MS representative as a direct connection to the assistance and services our members need. Our MS representatives help members before connecting them to subcontractors, other departments such as the BH Crisis or Health Information lines,, or community resources .



Figure 6.5.1-11: Easy-to-Access Services for Members
Aetna's MS representatives can support members in a variety of ways, including connecting them to essential services.

We are equipped to handle the first steps of inquiries and questions on behalf of our Care Connections, G&A, and member advocate, allowing for immediate resolution for callers if needed. For example, if a legal guardian calls to request an internal appeal or State Fair Hearing, we can explain the procedures for both and advise of member rights before linking with the Department staff; or if a member calls with questions related to Care Connections program services, our representative determines whether there are any other questions they can answer, such as locating a specialty provider, prior to offering a warm transfer. MS representatives provide appointment assistance with providers at the member's request. If requested, the representative completes a warm transfer to the provider and assists the member in securing a

date and time/scheduled appointment based on the provider availability and member preferences.

MS staff are trained and have desktop procedures that guide on how to identify emergencies and medical and mental/BH triggers and complete a warm transfer to care managers or clinicians with nursing or mental/BH expertise. Representatives initially offer concierge support using skills learned in training on **Mental Health First Aid, Trauma-Informed Care, and the unique needs of West Virginia members.** If a member expresses or describes emergency needs, the representative completes a warm transfer to 911 emergency services and documents accordingly, including notifying the Care Connections team for members enrolled. If a member expresses or describes mental health needs or a crisis such as struggles with depressed mood, the representative responds compassionately while sending an instant message to the Care Connections distribution list indicated in the crisis call desktop procedure. If the member is enrolled in a Care Connections program and it is during business hours, the representative completes a warm transfer to an available Care Connections staff. The representative keeps the member engaged on the phone, explaining the steps being taken and initiating the warm transfer. If the member is not enrolled in the Care Connections program and the concern indicates a need for immediate mental/BH crisis support, the representative follows

One of our valued members shared this information about a call to the MS department in January 2020: "My representative was very, very helpful because I did not feel well. I felt like I was sick. I was very nervous, and she helped me. She took the time to call (the) Prior Authorizations (department) and she also called my pharmacy, got back to me, and made sure she had helped me properly. She gave me all the proper information and I felt a lot better. I felt comfortable because I suffer from depression every day and she just made me feel so comfortable. I just want to tell her I really, really appreciated her, because you just do not know what people are going through when they call. She really took the time to really help me not knowing me and I just want to tell her I appreciate her. Thank you."

the same desktop procedure and initiates a warm transfer to clinicians on the BH Crisis Services hotline.

Our Care Connections team offers a comprehensive, integrated program and staff—licensed social workers and counselors, clinicians with nursing expertise, peer support, expert clinicians in chronic disease, substance use disorders, and specialty areas, and medical directors—available during business hours to handle incoming transfers from our MS department. The Care Connections team is trained extensively in the unique needs of West Virginia members, and possesses the education, experience, and skill to resolve our members' clinical or crisis concerns.

On both the BH Crisis Services hotline and the Health Information line, clinicians can complete warm transfers of members to their assigned care manager during business hours when care coordination is needed, or when a change in the member's needs requires reassessment or a new referral. The health care professional documents in the same electronic CM system, creating an alert for the specific assigned care manager to follow up on a member's individual service plan—a critical resource that benefits members by providing **seamless continuity of care.**

Our BH Crisis Services and Health Information lines use the same telephone system and call technology as our MS department. The hotlines use an IVR system that routes members to the appropriate staff. Members whose preferred language is Spanish can choose the option to route to a Spanish-speaking clinician; if the call is routed to a clinician who speaks English only, the clinician can immediately engage our 24/7/365 interpretation services at the onset of the call. The clinician receives a whisper tone indicating the caller is Spanish-speaking and sees a

written readout on the face of their telephone notifying that support is needed for a Spanish-speaking caller. If all clinicians are currently assisting other callers, the system places the caller on a brief hold and connects the member to the next available clinician in the call queue.

[MS019] Member Services Training

Aetna's dedication to our **Common Purpose** means educating, empowering, and deploying a highly skilled workforce. This approach is part of Aetna's mission to recruit and retain a local, West Virginia workforce that operate with integrity and transparency. Our MS department's exemplary training program starts with hiring and staffing experienced, expert customer service professionals who handle a wide variety of functions and responsibilities, assuring an optimal member experience. We staff our call center based on the unique member needs of West Virginia including membership estimates, historical data on local and other market call volume trends, and Department-required performance standards. Our call center staffing includes comprehensive forecasting methods implemented collaboratively with our national Workforce Management department and includes per member per month (PMPM) call rates, average call handling time, time needed for training, meetings, and lunches/breaks, and other factors. To determine our staffing projections we forecast, on a monthly basis, for future months. We make staffing adjustments hourly, daily, and weekly, as call volume needs change. Since there is historically an increase in calls during new business implementation, we forecast at higher PMPM rates and longer call handling times to account for an increase in calls from new members. During that

> One of our valued members shared this information about a call to the MS department in January 2020: "The representative that I just talked to on the phone, she was very, very polite, she was courteous, and I definitely enjoyed her customer service skills. Overall, she was prompt to answer my questions, she made sure that everything I needed was addressed. Today has been kind of an annoying day and she helped me get through it, so I appreciate everything and the training she has received from Aetna."

timeframe, typically three months, we make certain additional staff are available to answer calls and meet our new members' needs. Our current member-to-representative ratio is less than 10,000:1. **[MS021]** This ratio would change with new membership such as WVCHIP.

We proactively hire and use fully trained overflow staff from other call centers and adjust call queue skills to make certain our call center performance is within Department requirements. We will train all existing West Virginia MS call center staff on the changes to the West Virginia MHT, WVHB, and on the WVCHIP contract, assuring an adequate number of representatives to handle incoming calls and concerns. **[MS019]** Our staffing approach is agile by design, as we analyze past call volume data and call center performance. For example, due to an influx in membership and calls, we can adjust swiftly to meet the needs of our members, as described in Call Center Tracking, Monitoring, and Performance section.

Aetna **leverages our national training expertise and local experience to incorporate the needs of West Virginia members into our comprehensive training processes** for the MS staff. MS staff complete three weeks of classroom, online, and interactive training during new-hire initial training, described in **Table 6.5.1-2**. **[MS019]** We accommodate diverse learning styles by using multiple training modalities and exceed industry standards with a student-to-trainer ratio of 15:1 or lower. The staff practice responding to scenarios that focus on concerns they are likely to receive from West Virginia members and existing supervisory staff role-play responding to the scenarios. Initial training includes direct oversight of their performance through job shadowing and observation with a preceptor before they have contact with members. Preceptors demonstrate how calls/emails are handled, how to operate the telephone, email, and documentation system, how to navigate resources, and best practices for resolving

members' concerns. After observing the preceptor, the representative takes calls with the preceptor observing and coaching on live calls and emails. Training is reinforced through monthly call/email audits that include review of topics such as greeting, ID, telephone etiquette, call servicing, documentation, and West Virginia program requirements. Supervisors complete audits, review scores, and identify areas for improvement with staff, monthly, or more frequently depending on need. Additionally, **our entire MS department received training in Lean Six Sigma**—an approach for efficient problem-solving that creates value for our members and the State. Staff members are trained to solve problems in ways that are efficient and effective, allowing for an exemplary member experience.

Aetna uses multiple, ongoing training approaches to reinforce content learned. Staff sign acknowledgement of understanding forms and participate in daily debriefs with their supervisors Training is provided by the senior representatives during bimonthly staff meetings and representatives have quarterly training on quality initiatives such as documentation and exemplary member experience practices and culturally competency. They receive on-the-spot, real-time support from senior representatives through chat and instant messaging and engage in annual classroom training and online webinars. We review and update the training curriculum annually or as programs change to follow Department requirements, state and federal laws, and West Virginia regulations.

One of our valued members shared this information about a call to the MS department in January 2020. This call was with a newly hired representative who recently completed his shadowing with a preceptor who has been employed with the Aetna MS department since the West Virginia call center went live: "John[9] was very nice, helpful, and professional. He was very good to me and talked to me about my situation which I was very upset about. Thank you, Aetna, for helping me."

[9] Not his real name

We update and provide additional trainings as needed when we have new systems that require navigation, when West Virginia programs are updated, and when trends indicate a need for additional training. For example, our Service Improvement Committee recently redefined how we capture provider dissatisfaction to make sure our complaint resolution is actionable. As part of this effort, MS representatives were trained on the new definitions and procedures for documenting and tracking complaints. We incorporate feedback gathered from automated surveys, quality satisfaction surveys, and the Member Advisory Committee into our training curriculum. Representatives receive training reminders and have access to e-learning tools (e.g., online, self-paced training modules, search engines, desktop references and guides, and written training materials). Aetna addresses training for MS during new-hire onboarding, monthly department trainings, and annual refresher trainings on items such as the code of conduct, Healthcare Insurance Portability and Accountability Act (HIPAA), protected health information, fraud, waste, and abuse, and record retention.

Training topics include **MHFA, trauma-informed care**, ongoing BH training via Relias Learning Management System, technology-based training via the Aetna Learning and Performance Center, and any other Department-specific training. Aetna designates time off the phone for representatives to complete scheduled training. **Table 6.5.1-2** outlines training topics, curriculum description, and the training timeline.

Table 6.5.1-2: Member Services Training Curriculum [MS019]

Training Topic	Training Curriculum Description	Training Timeline/Frequency
Covered and VAS	Overview of covered services including physical, mental/behavioral, and preventive services, role of the PCP and assignments, how to access services, how to provide appointment scheduling assistance, out-of-network services,	New-hire initial training and as program changes occur; monthly training on mental/BH services; current staff upon program implementation

Training Topic	Training Curriculum Description	Training Timeline/Frequency
	limitations, and medical necessity; the member handbook; member G&A; Aetna's VAS and related benefits	
West Virginia Requirements	Overview of Medicaid and WVCHIP program and related requirements including member rights, member G&A, and advance directives, waived copays for WVCHIP members enrolled in PCMH; unique needs; community resources unique to MHT, WVHB, and WVCHIP members; regional and service area distinctions	New-hire initial training, as program changes occur, current staff upon program implementation
Member Rights, Enabling Services and Cultural Competency	Overview of member rights, enabling services, federal regulations, and State requirements; fraud, waste, and abuse; overview of cultural competency including Aetna values, ethics, diversity, health care equity, disparities, health literacy, regulatory requirements, language differences, National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, Medicaid program unique needs, oral interpretation and written translation services, **[MS042]** use of teletypewriter, culture of disability, disabilities and chronic conditions, and disability accommodations	New-hire initial training, annually
Assisting Members with Limited English Proficiency [MS032]	Overview of West Virginia population, engaging members with LEP, and instructions on how to access 24/7/365 subcontracted interpreter and translation services	New-hire initial training
Assisting Members in Locating Providers and Community Resources	Review of member handbook, instructions on how to navigate Aetna's secured portal, website provider search function, and mobile application; overview and navigation instruction for community resource databases, Aetna's internal database and local community	New-hire initial training

Training Topic	Training Curriculum Description	Training Timeline/Frequency
	resources available to members (e.g. Aunt Bertha, Unite Us)	
Service Excellence	Overview of Aetna service excellence standards, call center conduct and expectations, soft skills, use of phone, instant messaging, website, and internal databases and systems, problem-solving, taking and responding to complaints	New-hire initial training
How to Manage Crisis and Clinical Calls	Overview of Health Information line and BH Crisis Services hotline; review of procedures for when and how to refer; instructions on how to access both; warm transfer and escalation protocols; how to inquire about life-threatening illnesses; how to access 911 and emergency services; triggers for medical or mental/BH crises; warm transfer and escalation protocols; using principles identified in Mental Health First Aid and trauma-informed care with callers	New-hire initial training
Members with Special Healthcare Needs	Overview of members with special healthcare needs, outreach and transition planning, members with chronic conditions, Mental Health First Aid, and trauma-informed care	New-hire initial training, as program changes occur
Privacy and HIPAA	Overview of HIPAA, privacy regulations, appropriate use of sharing information, State and federal laws, member rights and protection, Medicaid requirements, confidentiality, ethical code, HIPAA safeguards and compliance, and preventing fraud, waste, and abuse	New-hire initial training, annually
Abuse, Neglect, and Exploitation	Description of State mandated reporting requirements, policies, and required forms	New-hire initial training, annually
Member Advocacy	Overview of member advocate role and responsibilities, complaint and internal appeal process, and State Fair Hearing process	New-hire initial training, as program changes occur

[MS020 – MS026] Customer Service Performance

Aetna has superior call center monitoring practices that result in exceeding the Department call center performance standards. We use local and integrated telephone solutions to support members' needs quickly and efficiently. For example, during times where call volume may increase, MS supervisors and our Workforce Management department monitor telephone performance and call routing in real time and address calls waiting in the queue, making sure that every West Virginia member's call is handled efficiently. Call monitoring trends are used to project future staffing levels, assuring our MS department is sufficiently staffed to respond to member needs. All calls are recorded and available for quality monitoring and 1:1 coaching with our MS representatives. We review calls for service excellence informed by our **Common Purpose**, accuracy of information provided, and adherence to policies via our call analytics, quality audit processes, and satisfaction surveys

Our enterprise telephone system includes a suite of tools enabling MS supervisors, managers, and our national Workforce Management team to respond to daily, weekly, monthly, and seasonal trends in call volume. **[MS020]** We use these tools to track and trend performance including service levels such as call answering time, call abandonment rates, and single-call resolution. **[MS022, MS023, MS024]** We adjust staffing accordingly, anticipating future call volume (i.e., forecasting)—**a quality-driven process** that allows us to meet West Virginia MHT, WVHB, and WVCHIP members' needs and consistently exceed the performance standards established by the Department. Forecasting data from both our West Virginia and Arizona call centers is used to determine staffing and create schedules with enough staff to address member needs and not only satisfy but exceed the Department performance standards.

Aetna's dedicated Workforce Management staff uses tools that allow for immediate response to changes in telephone call volume. In the case of an emergency with increased call volume such as a natural disaster, our business continuity planning includes immediate connection to West Virginia trained MS representatives from other Medicaid plans. This occurs quickly and seamlessly, as cross-trained representatives are already skilled, and indicated in our call queues and enterprise telephone system as West Virginia-trained and ready to accept a call. When call volume increases, calls are automatically routed to additional trained representatives in the West Virginia call queue. Aetna also offers high-performing MS representatives the opportunity to work at home. Should localized situations affect the primary office (i.e., flooding, electrical outages, etc.), our work-at-home staff **support business continuity without service interruption.**

Aetna monitors the quality and accuracy of calls through our quality management processes including speech analytics and satisfaction surveys. All calls are recorded for quality assurance and stored in our electronic database. Aetna has designated quality analysts who review, at minimum, four calls per month per representative, which is documented in the electronic, phone recording system. MS representatives have access to their individual quality audits in the electronic phone recording system and can access the call and feedback from the quality analyst at any time. Senior MS and supervisory staff do a formal review of call audits and feedback, and provide coaching, constructive feedback, and kudos to representatives as needed, scheduling 1:1 direct supervision where required. In addition to post-call member surveys, we measure other areas through call analytics such as customer satisfaction and first-call resolution. We also use speech analytics to identify issues. Supervisors use this technology to determine opportunities to enhance our policies, procedures, and training, making our

Common Purpose come to life. For example, we often find opportunities to improve our processes and procedures through our quality management, call analytics, and satisfaction survey processes. By listening to audited calls, we have learned that when members call with questions about their PCP, we have an opportunity to educate them about locating PCP information using our secure member portal or mobile application on their smartphone. We have trained our representatives to provide this education at each available opportunity and added to our call audit checklist, enhancing our representative's ability to provide service excellence.

Aetna has written procedures that guide and support effective remediation of call center performance. **[MS026]** Our procedures inform our MS call center leadership who are responsible for remediation and who evaluate trends, monitor call queues, and implement remediation strategies to make sure we achieve service excellence. Our West Virginia MS leadership utilize and implement the following strategies depending on the circumstances impacting performance when remediation is required:

- Collaborating with Aetna Workforce Management department to evaluate trends, review staffing patterns, and adjust call center forecasting, determining the adequate number of representatives to handle the volume of calls at required performance thresholds
- Adjusting meetings, supervision, or trainings to lower, call volume timeframes
- Offering additional shifts and, when necessary and within policy, overtime to make sure we have proper coverage
- Closely monitoring adherence to breaks, lunches, and call documentation timeframes
- Training additional representatives on high volume calls and adding representatives to the applicable call queues when call volume dictates; add leads and supervisors to call queues during high volume timeframes
- Assuring paid time off P&Ps reflect the needs of the call center and high call volume days/times
- Consulting with department manager or plan leadership if temporary staff are needed
- Assuring timely and proper training, coaching, and skill level

Aetna demonstrates our commitment to West Virginia through superior performance in customer service standards identified by the Department. We have exceeded Department performance

standards in the last two calendar years, taking high volume of calls with nearly **100 percent resolution the caller's issue during the first, initial call (single-call resolution).** We adhere to the Department's requirements for customer service performance standards reporting in our Medicaid program and will continue to adhere to all reporting requirements identified for West Virginia MHT, WVHB, and WVCHIP program. **Table 6.5.1-3** outlines our most recent performance for 2019, year-to-date.

Table 6.5.1-3: Member Services Call Center Performance Standards [MS022 – MS023, MS024]

Calendar Month	Calls Answered	Service Level, or Calls Answered in 30 Seconds (State Requirement 83%)	Abandonment Rate (State Requirement <5%)	Single Call Resolution[10]
2018	36,285	**88.35%**	**1.40%**	**99.30%**
2019	44,591	**91.35%**	**1.56%**	**99.34%**

[10] Single, or first call resolution, is defined as properly addressing a member's need the first time they call, thus eliminating the need for a return or outbound call back.

6. Enrollment and Disenrollment

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Enrollment and Disenrollment (ED) as part of their bid. The Vendor's narrative response should not exceed 25 pages.

Aetna's national Medicaid organization has over 30 years of continuous, active participation in Medicaid managed care. Aetna's goal is to make member enrollment as seamless as possible by leveraging our extensive experience managing member enrollment and disenrollment in our health plans across the country. Our Enrollment Services department, and our enrollment and disenrollment information system and related application capabilities are structured to accommodate the requests and requirements of West Virginia Bureau for Medical Services' (Department) Medicaid Managed Care program, which maintains the sole authority in determining eligibility and enrollment membership.

Policies and Procedures Regarding Member Enrollment

ED001	The Vendor should describe its policies and procedures regarding enrollment of members, including the processing of 834 enrollment files.

Aetna has a successful ten-year history working with the Department using Health Insurance Portability and Accountability Act-compliant Benefit Enrollment and Maintenance (834) transactions to process and reconcile member enrollment data. We will follow our current, documented, and Department-approved policies, procedures, and processes for receiving and processing enrollment data to manage our Mountain Health Trust, West Virginia Health Bridge, and West Virginia Children's Health Insurance Program (WVCHIP) membership.

Member Enrollment and Enrollment File Processing Capabilities

Our member enrollment procedures and related technology applications are constructed to accept and process the eligibility data contained in the 834 transactions, which we load into our Enrollment Manager application. As illustrated in **Figure 6.6.1-1**, our Enrollment Services

department team identifies, researches, and validates exceptions, making the appropriate updates in our core information system and notifying the Department as required. We configured our Enrollment Manager application to extract all data elements in the Department's 834 file.

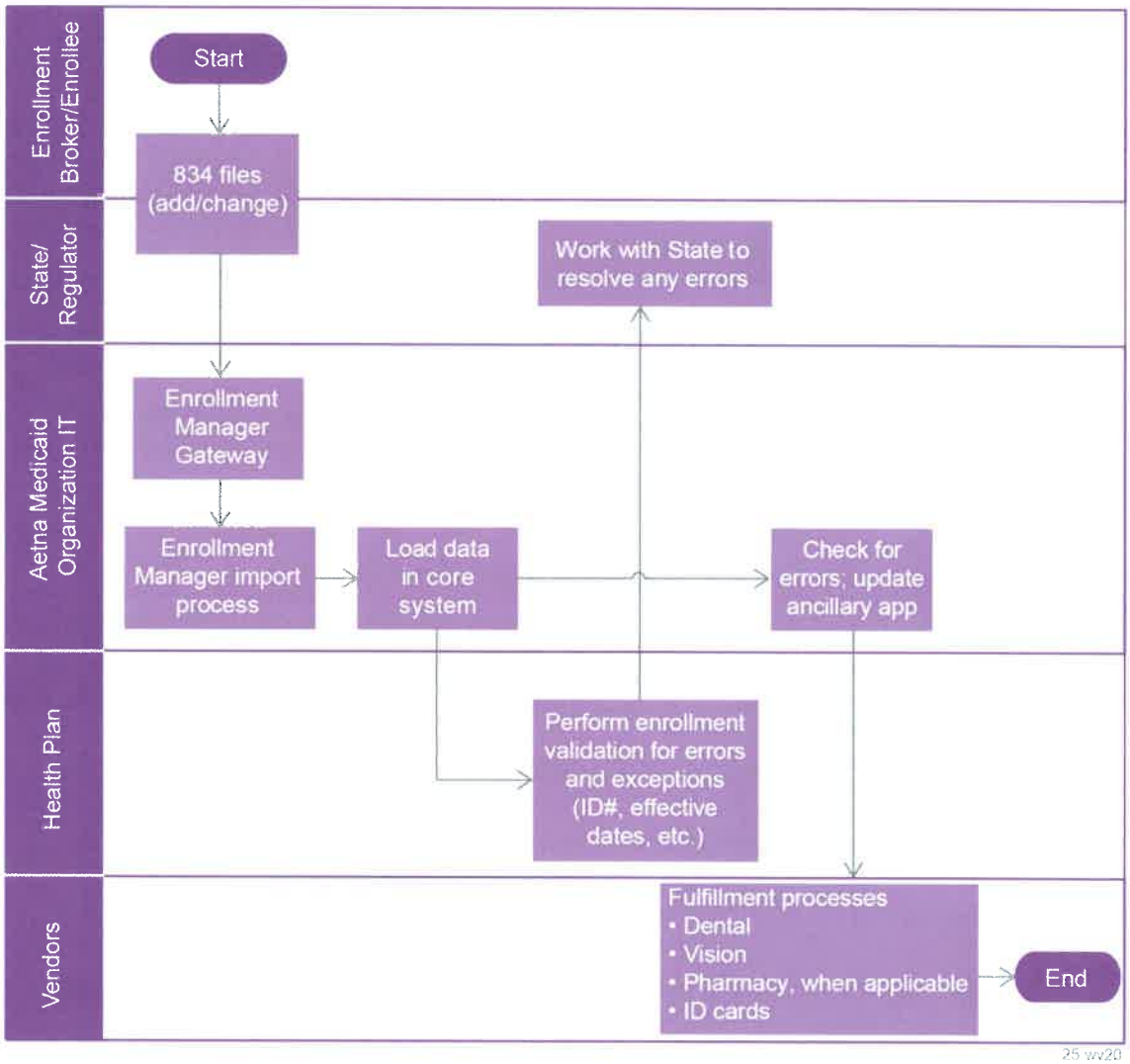


Figure 6.6.1-1: 834 Enrollment Process
This illustration shows our data quality controls and the flow of enrollment information from the member through to our vendors.

The following narrative describes our member enrollment policies, processes, and procedures.

Our Enrollment Services department team administers consistent processes for tracking

changes in enrollee eligibility and resolving related discrepancies. These processes include a review of monthly Health Insurance Portability and Accountability Act (HIPAA)-compliant benefit enrollment and maintenance (834) transactions to process and reconcile enrollment data as well as employing standard, documented, and approved processes and procedures for receiving and processing enrollment data.

Our Enrollment Manager technology application is designed to initially load and to subsequently update enrollment information that we receive from the Department. We will use the data contained in the Department's enrollment data files to manage Mountain Health Trust, West Virginia Health Bridge, and WVCHIP enrollee eligibility, and to authorize services and process claim transactions. We follow a set of enrollment policies and procedures to help us identify members from the 834 file who require immediate services and service coordination, and to identify opportunities to engage new members and maintain their continuity of care. Our enrollment policies also stipulate that covered benefits and medically necessary services are available immediately upon enrollment for every individual who is enrolled in our plan.

In July 2019, a West Virginian needing cancer care who required immunotherapy within 24 hours was accidentally excluded on the monthly 834 enrollment file we received from the Department, resulting in him not being enrolled in Aetna's systems. Upon notification from the Department, our Enrollment, Member Services, and Care Management teams all worked with the Department and the member to ensure the member was enrolled and that they received their scheduled treatment without interruption.

We follow these same enrollment policies and procedures to reconcile enrollee eligibility information between the 834 file and the enrollee files in our claims management system, including notifying the Department within five business days when we identify changes to the enrollee's circumstances that may affect the enrollee's eligibility status (including changes in the enrollee's residence, such as out-of-state claims, or the death of the enrollee).

We continually process 834 files and monitor the accuracy of our enrollment file contents against the Department's enrollment data. Our ability to maintain current and accurate enrollee data is critical to administering timely and accurate premium payment processing as well as accurate and appropriate eligibility verification and claims processing.

Our Enrollment Services department fully processes the 834 change files to our claims processing system within the required 24 hours. This effort includes both our automated and manual processing of 834 data to our claims processing system. Additionally, our Enrollment Services department fully processes 834 reconciliation files to our system within the required five business days.

When we complete our internal processing of 834 data, our Enrollment Services department team generates a set of 834 change and reconciliation extract files and distributes these files to our vendors within 48 hours from the time we complete our 834 change and reconciliation file processing efforts.

Please refer to **Table 6.6.1-1** for a summary of our West Virginia and national enrollment processing volume over the preceding 13-month period, which demonstrates our ability to load and manage 834 files for Medicaid programs ranging from a relatively few number of members to programs with large volumes of members (December 2018 and December 2019 are included to depict year-to-year results).

Table 6.6.1-1: 834 File Processing

Plan (Inclusive of December 2018 to December 2019)	File Type	Total 834 File Count	Total 834 Insured (INS) Count
All Medicaid Plans	Internal Change	11,515	13,851,976
All Medicaid Plans	Internal Reconciliation	684	35,691,185

Plan (Inclusive of December 2018 to December 2019)	File Type	Total 834 File Count	Total 834 Insured (INS) Count
Aetna West Virginia	Internal Change	13	5,889
Aetna West Virginia	Internal Reconciliation	13	1,738,313

Enrollment Electronic Data Interchange (EDI)

Aetna's data management policy requires we follow a secure and proven process for establishing and maintaining all EDI interfaces. We utilize a secure file transfer protocol server to handle inbound and outbound file exchanges. When establishing a new EDI interface, we collaborate with the Department and our trading partners to exchange key information required to establish the secure connection for exchanging files on both sides of the exchange.

To verify successful inbound and outbound file transmission, we employ an extensive combination of automated processes, which provide end-to-end validation to ensure successful exchange of inbound and outbound files and to alert our production services of any file transmission-related issues.

To augment these processes, our Production Support team uses a proprietary dashboard that provides an end-to-end view of a file's status through each intake step. This process identifies new member enrollments, disenrollments, discrepancies, and file fallout management, among other elements.

In addition, we configure our file monitoring software to automatically alert our Enrollment Services team in the event of a failure at any point in the file transmission process, which allows our production support to immediately research and resolve the file transmission failure.

Member 834 Enrollment File Import and Loading Procedure

We initiate our enrollment file import and loading procedure when we receive notification from the Department or its designated vendor for Mountain Health Trust, West Virginia Health Bridge, and WVCHIP enrollees via a secure File Transfer Protocol or electronic media. Our policy requires this notification occur as soon as possible following the Medicaid Management Information System (MMIS) cut-off date for the month, but no later than the last business day before the end of the month.

We configure the rules of our Enrollment Manager application to extract all data elements in the Department's 834 enrollment file, including waiver type of assistance, tiers type of assistance codes, rate code service groupings, and the member's effective and termination dates. Our workflow procedure also makes certain that we process any retro-enrollments or retro-termination dates in the system correctly. If an enrollee's benefit status changes, we create a new enrollment time span with correct effective and end dates. Our policy requires that these data elements trigger additional benefit changes, which we cascade to all our systems to ensure an enrollee's covered benefits match their eligibility type and benefit coverage categories across our applications, such as the pregnancy status of a female enrollee, beneficiaries eligibility for supplemental security income, WVCHIP enrollees, or individuals who are eligible for services covered by the Medicaid expansion population of adults, ages 19 to 64 category. We also send applicable member eligibility files to our dental and vision vendors, and in the past, our pharmacy benefit manager.

PCP Selection and Assignment Process

We provide freedom of choice for our members. If a member does not select a PCP with the enrollment broker during the choice selection period or at the time of initial enrollment, Aetna assigns a PCP using our comprehensive rules-based PCP assignment product, AssignADoc (AAD), as illustrated **in Figure 6.6.1-5**. AAD incorporates a number of key functions including geographical-based PCP assignments based on the member's location, language needs, and cultural needs, as well as any prior PCP relationship (if known). Members may contact our Member Services department to request a PCP change. Members may also submit PCP change requests on our secured Member Services website or mobile application.

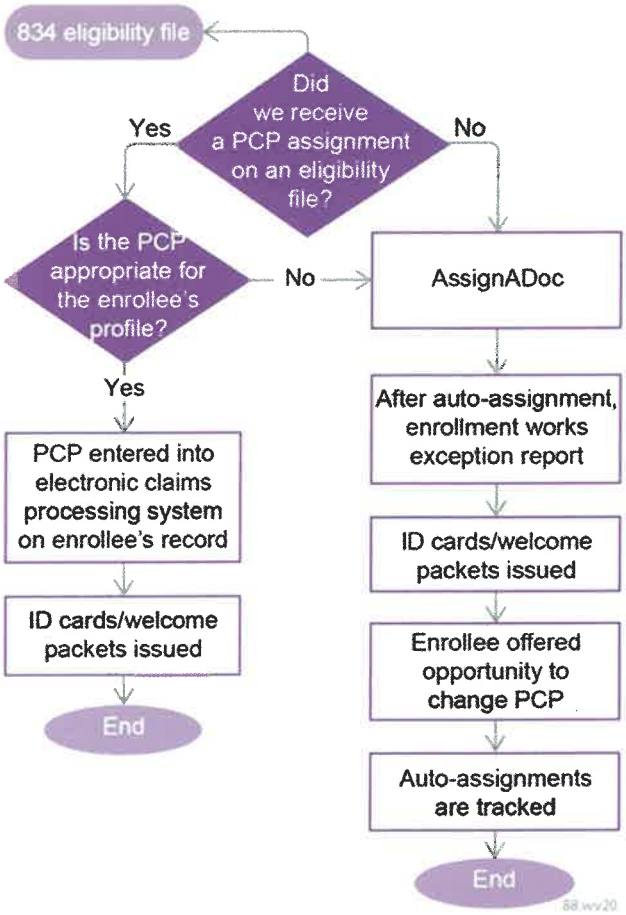


Figure 6.6.1-5: PCP Assignment Workflow
Aetna works closely with members to identify a PCP that matches their individual needs.

Member Enrollment File Validation and Reconciliation Process

Once Aetna receives the 834 files, we compare the member records to the existing data within our current enrollment records utilizing our Enrollment Manager Application. Each member record is reconciled through our highly configurable proprietary rules engine that considers **24 unique combinations of demographic data** that evaluates the following scenarios:

- Split, overlapping, duplicate, and consecutive enrollment segments
- Member matches
- Needed consolidation and transformation of the member information

- Proper updates to demographic, enrollment benefit plan assignments, PCP assignments, member classifications, and other critical information

Overall, this application is configured to administer our validation rules, balancing rules, and applicable PCP auto-assignment rules. We use the following hierarchy to determine member eligibility:

- Members who are continuously enrolled maintain the current PCP unless the managed care organization (MCO) is notified of a PCP change and a subsequent updated occurs in our system.
- If a member was previously disenrolled due to loss of eligibility but gains eligibility in less than two months, we can seamlessly bring the member back into our plan, assigning the member back to their same PCP and providing continuity of care.
- For newly enrolled members, the state's enrollment broker assists members by selecting currently credentialed Aetna PCPs and that information is sent on the 834.
- For those members who have not designated a PCP as indicated on our 834, our PCP auto-assignment algorithm applies a set of hierarchical business rules such as the member's physical ZIP code, family member PCP assignment, and prior PCP assignment using a look-back rule to support a member's continuity of care.

Please refer to **Table 6.6.1-2** for a summary list of the procedural actions we take to process and reconcile the monthly 834 enrollment and 820 capitation files we receive via the Department's eligibility contractor. Our enrollment processing and reconciliation rates consistently exceed the Department's accuracy and timeliness requirements.

Table 6.6.1-2: Enrollment and Capitation File Processing Procedures

Step Number	Procedural Action Taken	Description	Who Acts
834 Enrollment Change Files			
1	Receive from a secure file transfer protocol site and download 834 file from the Department's enrollment broker.	The files contain enrollee changes, including enrollee additions, terminations, and demographic changes.	Aetna Information Technology department
2	Process 834 change files.	All 834 member change files are processed within 24 hours of receipt (24/7/365). The Enrollment Services department is notified when the process is complete.	Aetna Information Technology department

Step Number	Procedural Action Taken	Description	Who Acts
3	Reconcile enrollee eligibility information between the 834 change file and the Aetna operating system.	Any data received that cannot be matched to the Aetna operating system or cannot be updated is worked manually by staff within 24 hours. Staff identifies, researches, and validates errors and exceptions, updating the system and notifying the Department as required.	Aetna Enrollment Services department
834 Enrollment Reconciliation Files			
1	Receive from a secure file transfer protocol site and download monthly 834 reconciliation file from the Department's enrollment broker.	The files contain the full enrollment information for the membership, including the Mountain Health Trust, West Virginia Health Bridge, and WVCHIP eligibility period, physical health MCO coverage, behavioral health MCO coverage, and other enrollee demographic information. There is only one record for each Mountain Health Trust, West Virginia Health Bridge, and WVCHIP enrollee (the most current) where the enrollee is eligible the first of the following month.	Aetna Information Technology department
2	Process the monthly 834 reconciliation file.	The monthly reconciliation file is processed within 24 hours of receipt. The Enrollment Services department is notified when the process is complete.	Aetna Information Technology department
3	Reconcile enrollee eligibility information between the 834 reconciliation file and the Aetna operating system.	Any data received that cannot be matched to the Aetna operating system or cannot be updated is worked manually by staff within 5 working days. Staff identifies, researches, and validates errors and exceptions, updating the system and notifying the Department as required.	Aetna Enrollment Services department

Step Number	Procedural Action Taken	Description	Who Acts
820 Capitation Reconciliation File			
1	Receive from a secure file transfer protocol site and download monthly 820 file from the Department's fiscal agent.	The monthly file contains payment detail for current and retro-membership as well as any manual adjustments issued by the Department's fiscal agent.	Aetna Information Technology department
2	Reconcile enrollee eligibility information between the 820 payment file and the Aetna operating system.	The monthly reconciliation file is created and identifies enrollment issues that result in financial discrepancies. Finance reviews the file and notifies the Enrollment Services department of eligibility discrepancies.	Aetna Finance department and Enrollment
3	Research enrollee eligibility discrepancies received from Finance against Aetna's operating system, the 834 file, and the Department website if needed.	Enrollment reviews the eligibility discrepancies, provides resolutions, and sends the resolutions back to Finance.	Aetna Enrollment Services department
4	Reconcile capitation between Aetna and the Department.	The Enrollment resolutions are reviewed by our Finance department and coordinates with the Department to resolve discrepancies in capitation.	Aetna Finance department

In situations where a member's enrollment information has not been sent to us on an 834 file or there is a discrepancy in the 834 data that prevents a member from accessing their care, we promptly contact and coordinate with the Department, so our systems reflect the most accurate member enrollment data. Aetna works with our providers to ensure 834 data-related enrollment discrepancies will not impact a Mountain Health Trust, West Virginia Health Bridge, or WVCHIP member's ability to access services.

Member Enrollment File Errors and Exceptions Resolution Process

After we complete the upload of the 834 data file to our system, our Enrollment Manager application produces an edit report of errors and exceptions we identified between the 834 data file and our enrollment file. Our Enrollment Services department uses this report to research and manually validate enrollment-related errors and exceptions against our enrollment business rules, such as processing of newborn accounts, validating the status of enrollees in nursing homes, or verifying enrollees who are now deceased (please refer to **Table 6.6.1-3** for sample of Aetna's error and exception business rules). We then apply our applicable enrollment policies to make the appropriate updates in our core information system and notify the Department as required. Our policy defines errors as 834 file records that do not process into our core information system and require manual review and reconciliation. In addition, we define exceptions as 834 file records that process in our core information system but require manual validation of the file processing changes.

Table 6.6.1-3: Sample Enrollment Error and Exception Business Rules and Resolution

Internal Reported Error or Exception	Error or Exception Reason	Aetna Action Taken
Newborn enrollee assigned multiple identifications (IDs)	Often the result of the enrollee being a twin	Verify each sibling in MMIS and update QNXT manually for each sibling.
Multiple open enrollments rejected	State MMIS or overlapping enrollment segments	Verify by reviewing MMIS for multiple enrollment segments and update QNXT manually.
Discrepancy in termination dates	Newborn termed within the 90 days of coverage	Verify by reviewing MMIS, resolving discrepancy and manually update QNXT.

Internal Reported Error or Exception	Error or Exception Reason	Aetna Action Taken
Unable to identify QNXT benefit	Often the result of a timing issue resulting from updates to records within QNXT	Often resolved through the subsequent 834 data load. However, if not resolved through the subsequent 834 data load, a manual review against MMIS will occur. QNXT is updated manually.
Discrepancy in enrollee name	Possibly enrollee had a name change and system updated	Verify by reviewing name in MMIS. QNXT updated manually.

If the 834 file contains insufficient member eligibility information, our Enrollment Services department uses the Department's online eligibility verification system to determine the correct member eligibility information. If any 834 file records cannot be reconciled in our core information system, using the 834 file and/or the Department's eligibility verification system, our Enrollment Services department generates a report of those file records and sends this report to the Department within 30 days. The Department then sends us clarifying information on the status of these 834 records.

We process the aggregated monthly reconciliation files using the same procedure and processes we use to manage the 834 enrollment files. We receive the monthly change file approximately the 25th day of each month and the full 834 enrollment file on approximately the last day of each month. Our Information Services department loads each of these files within 24 hours of receipt into our claims processing system. This process automatically updates our claims processing system with the most current member enrollment information. In addition, this process generates an error and exception report, which contains member file records we manually review and update as needed.

Resolving 834 Member File Discrepancies

Our goal is to make enrollment as seamless as possible for our West Virginia members by leveraging our extensive experience managing the enrollment process in all our markets. We perform a number of validated processes to resolve 834 member file discrepancies if an enrollee's enrollment file does not process correctly. Over the last few years supporting the Mountain Health Trust program, we have adopted the following activities to address these file discrepancies:

- We train our Aetna Member Services representatives to validate member enrollment-related terminations or gaps in coverage against the Department's enrollment system.
- If we identify an 834 member file discrepancy, such as through a vendor interaction, we send an expedited referral to our Enrollment team for resolution.
- Our Enrollment team utilizes their enrollment validation resources, as described above, to resolve discrepancies and to update our internal systems upon resolution of the discrepancy.

Member Enrollment Innovations

To provide greater efficiency and accuracy of enrollment record handling, we will be deploying artificial intelligence (AI) capability for our West Virginia plan to improve our eligibility file processing quality, to preserve data integrity, and to reduce manual intervention associated with analyzing and resolving these data issues. This AI-based solution will use anomaly detection, a technique used to identify unusual data patterns or enrollment data anomalies that do not conform to expected data patterns. When data anomalies are identified through this AI-based approach, the enrollment process is automatically paused, and we initiate a manual review to resolve the anomaly. The enrollment-related product capabilities include the following benefits from this AI solution:

- New enrollee with insufficient enrollment information
- Identify eligible benefit
- Enrollment termination
- Term/void by absence
- Enrollment benefit change: term/void and reinstate

Policies and Procedures Regarding Member Disenrollment

ED002	The Vendor should describe its policies and procedures regarding disenrollment of members, including processes for reconciliation of members against the monthly 820 capitation file.

Aetna has developed and follows a set of member disenrollment policies and procedures that have been approved by the Department. These policies and procedures, which are described below, include processes for reconciling members against the monthly 820 capitation file. Our disenrollment policy stipulates that we will not process a member disenrollment unless the Department, which has the sole authority to disenroll members, has directed or approved this action. Our process for reconciling members against the monthly 820 capitation file starts with downloading the monthly 820 file from the Department's fiscal agent using a secure file transfer protocol site. We then reconcile member eligibility information between the 820 payment file and our operating system. If we encounter any member enrollment issues that result in a financial discrepancy, our Finance department reviews the file and notifies our Enrollment Services department. Our Enrollment Services department then researches these discrepancies against our operating system, the 834 file, and the Department's website, if needed. Upon resolution of all discrepancies, our Finance department reviews the reconciled results and coordinates with the Department to resolve the capitation discrepancies.

Member Disenrollment Policy

Aetna complies with the Department's voluntary and involuntary disenrollment requirements. We instruct members, who wish to disenroll from our plan, to contact the Department to request the disenrollment. If a member contacts Aetna's Member Services staff to be disenrolled, we determine the reason for disenrollment and quickly facilitate a warm transfer, when possible, to the Department's enrollment broker to support any continuity of care issue(s).

Aetna advises members that disenrollment requests must be submitted orally or in writing to the West Virginia-designated enrollment broker. Aetna understands that a member disenrollment will become effective on the first day of the month following the member's disenrollment request and authorization by the Department.

Member Disenrollment Reasons

Members may elect to disenroll from Aetna with or without cause. For example, disenrolling without cause may occur when a member voluntarily chooses to change managed care organizations. Additionally, a member could disenroll without cause when the member seeks providers of services that occur concurrently and at least one of those providers is not enrolled or credentialed in the Aetna network, or when the member's PCP has left the Aetna network for another plan and the member has chosen to follow the provider to the alternate plan.

Conversely, a member may disenroll with cause based on one or more of the following reasons:

- Aetna does not cover the service based on the precedence of the covered services identified by the Department and does not refuse to cover the service based on moral or religious objections
- Member needs related services to be performed at the same time and:
  - Not all related services are available within the network, such as a service requiring complex case management with a particular center of excellence located in another state
  - The member's PCP determines that receiving the services separately would subject the enrollee to unnecessary risk
- Member cannot receive needed care in the Aetna network including for the following reasons:
  - Lack of access to services covered under the contract
  - Lack of providers experienced in dealing with health care needs

Aetna requests enrollee disenrollment due to the following reasons:

- Member is determined to reside out of the service area
- Member is determined to be an excluded population
- Member is determined to be deceased
- Member is determined to be incarcerated
- Continuous placement in a nursing facility, state institution, or intermediate care facility for individuals with intellectual disabilities for more than 30 calendar days
- Member is determined to have an excluded condition

Aetna does **not** request enrollee disenrollment due to the following reasons:

- Change of enrollee health status
- Enrollee's utilization of medical/behavioral health services
- Enrollee's diminished mental capacity resulting in difficulty to provide services with one exception: the enrollee's capacity results in serious impairment of Aetna 's ability to provide services to enrollees or other enrollees
- Enrollee exercises their right to file an appeal or grievance

Disruptive Member Transfer

Aetna will not initiate disenrollment of an eligible member.

Retro-disenrollment

Our Enrollment Services department runs a monthly report of retro-disenrolled members, capturing any claims paid data, and forwards that detail to the Claims department for possible recoupment.

Disenrollment Procedure

Under the direction of our chief operations officer, our Enrollment Services department is responsible, with the support of our Member Services and Information Technology departments, for maintaining current enrollee records, for confirming that enrollee disenrollment requests received on the 834 files are accurately processed and updated in our core information system, and for reconciling members against the monthly 820 capitation file, either manually or through electronic transmission.

Aetna's Enrollment Services department processes disenrollment requests confirmed with the Department, updating our core information system with the appropriate termination date. We remove members' eligibility from our core information system weekly or monthly via a secure electronic interface between the Department and Aetna. We complete reconciliation of enrollee disenrollment information as needed. All enrollee disenrollments become effective no later than the first day of the second month after the transfer/disenrollment was requested.

Policies and Procedures for Retroactively Enrolling Newborn Children

ED003	The Vendor should describe its written policies and procedures and protocols for enrolling newborn children of members retroactively to the time of birth and transferring newborn information to the Department for processing.

In addition to our extensive experience with standard enrollments, our enrollment procedure includes a robust enrollment process for identifying specialized populations, such as pregnant members from the rate code field in the enrollment file, and other populations such as newborn children. For example, when we receive a birth notification, we confirm the mother's eligibility and review related utilization management (UM) documents to verify the mother was pregnant. Upon the completion and validation of these steps, we enroll a newborn child retroactively to the time of birth into our claims management system with a temporary ID number consisting of the mother's ID number and a prefix of 'NB'. This step, in our procedure, ensures seamless processing of UM documents, ID cards, the member handbook, and claim payments. At this point, we notify the Department of the newborn child's birth to verify the newborn child's mom's income and to determine benefit coverage levels. When we receive the newborn child's records on the 834, our Enrollment Manager application is configured to match the newborn child member ID to their mother's member ID using their shared case number. Our application will store matching case numbers for family members so that they are all linked in our system, but each enrollee will keep their own unique identification number. Our Enrollment Services department uses an audit report to ensure all temporary newborn children IDs are reconciled and accounted for using the 834 file or working with the Department to validate eligibility. We report unmatched members to the Department monthly.

Our Enrollment Manager application utilizes a set of validated enrollee matching rules to ensure file records, including newborn children, are accurately matched to existing records in our system when processing 834 files (please refer to **Figure 6.6.1-7**).

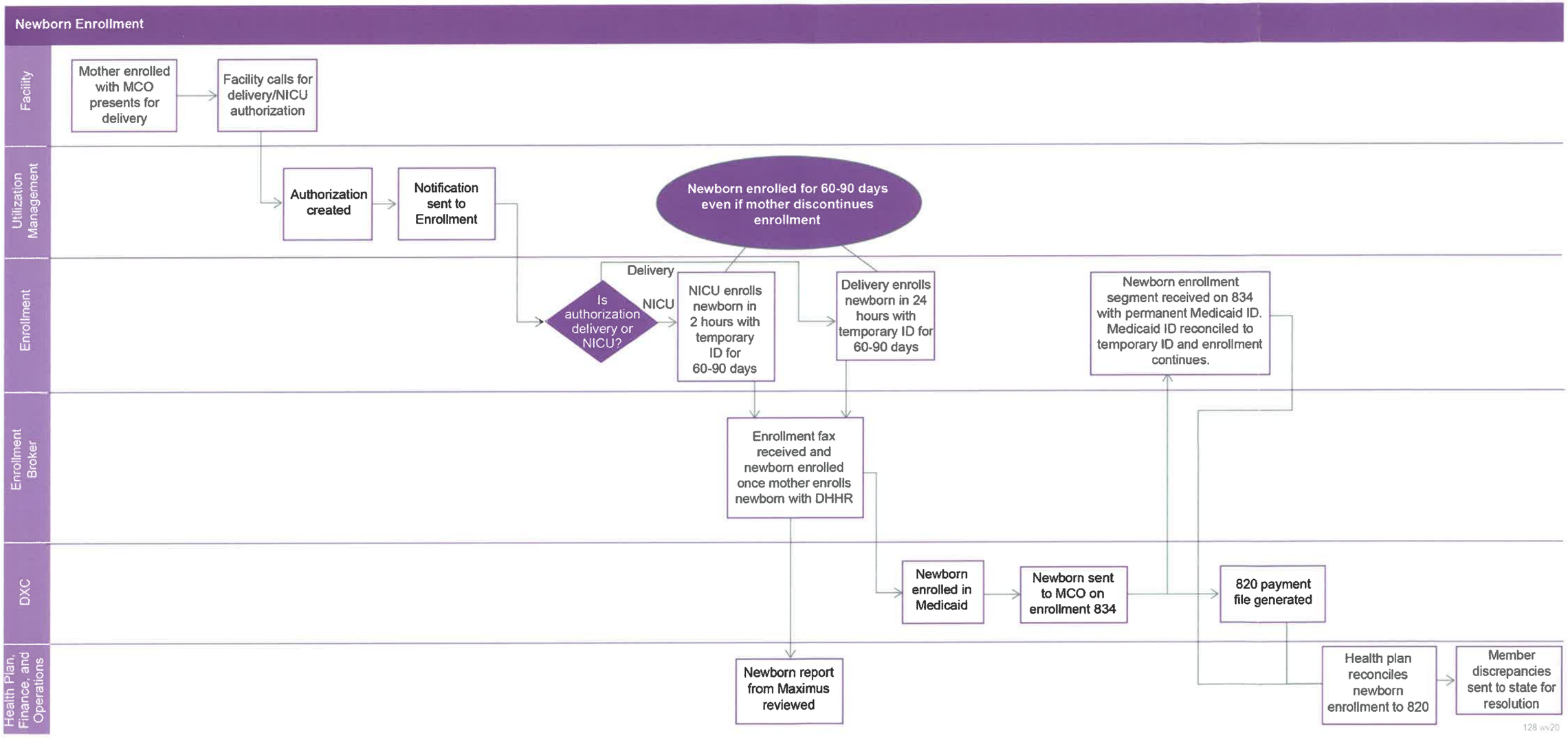


Figure 6.6.1-7: Newborn Enrollment Encounter Process

We use a comprehensive set of enrollee matching rules to ensure file records (including newborn children) are accurately matched to existing records in our system.

Newborn Coverage Protocol When Mother is no longer Enrolled

ED004	The Vendor should describe its protocols to cover newborns even if the mother does not remain enrolled after the newborn's date of birth.

Aetna has developed and manages to an enrollee transition policy, which has been approved by the West Virginia Department of Health and Human Resources BMS. When Aetna receives notification of a newborn child from the member or the hospital, for example, we enroll the newborn child immediately as a member and we are responsible for all of the baby's medically necessary services for the first sixty to ninety calendar days of life based on the cut-off date for MCO enrollment with the enrollment broker. The child's date of birth is counted as day one. We ensure all provider charges are appropriately reimbursed during the inpatient newborn child's hospital stay when the newborn child is born to a mother who is a current Aetna enrollee and until the newborn child is discharge, even if the mother does not stay enrolled. Our Enrollment Manager application utilizes a set of validated enrollee matching rules to ensure file records, including newborn children even if their mother is not enrolled with our MCO, are accurately matched to existing records in our system when processing 834 files (please refer to **Figure 6.6.1-7**). Aetna will submit newborn child enrollment forms to the Department's enrollment broker within 60 calendar days of the date of delivery or as soon thereafter as the MCO becomes aware of the delivery.

Transfer of Maternity Care

Pregnant members who transfer into Aetna in the second or third trimester of their pregnancy may elect to continue with their current maternity practitioner, including an out-of-network practitioner, through the postpartum period. A practitioner who is currently providing maternity care to an enrollee who is transferring into Aetna should contact the receiving health plan to

obtain authorization for continuing the member's services. Alternatively, an enrollee may contact her perinatal case manager for assistance in obtaining authorization for continuation of services.

Member Disenrollment and Transferring Member Information

ED005	The Vendor should describe its written policies and procedures for transferring relevant member information, including medical records and other pertinent materials, when a member is disenrolled from the Vendor and enrolled with another Vendor.

We follow our transition of care and member enrollment policies and corresponding procedures when a member is disenrolled from our plan and enrolls with another plan. When a member contacts Aetna Member Services or Care management directly to be disenrolled, we attempt to resolve the reason for disenrollment following the same system described previously. If the issue cannot be resolved, we quickly facilitate a member transfer to the Department for continuity of care. Our policy stipulates that our documented disenrollment resolution process focus on ensuring the member receives the care they need in a timely fashion (Please see **Figure 6.6.1-8**).

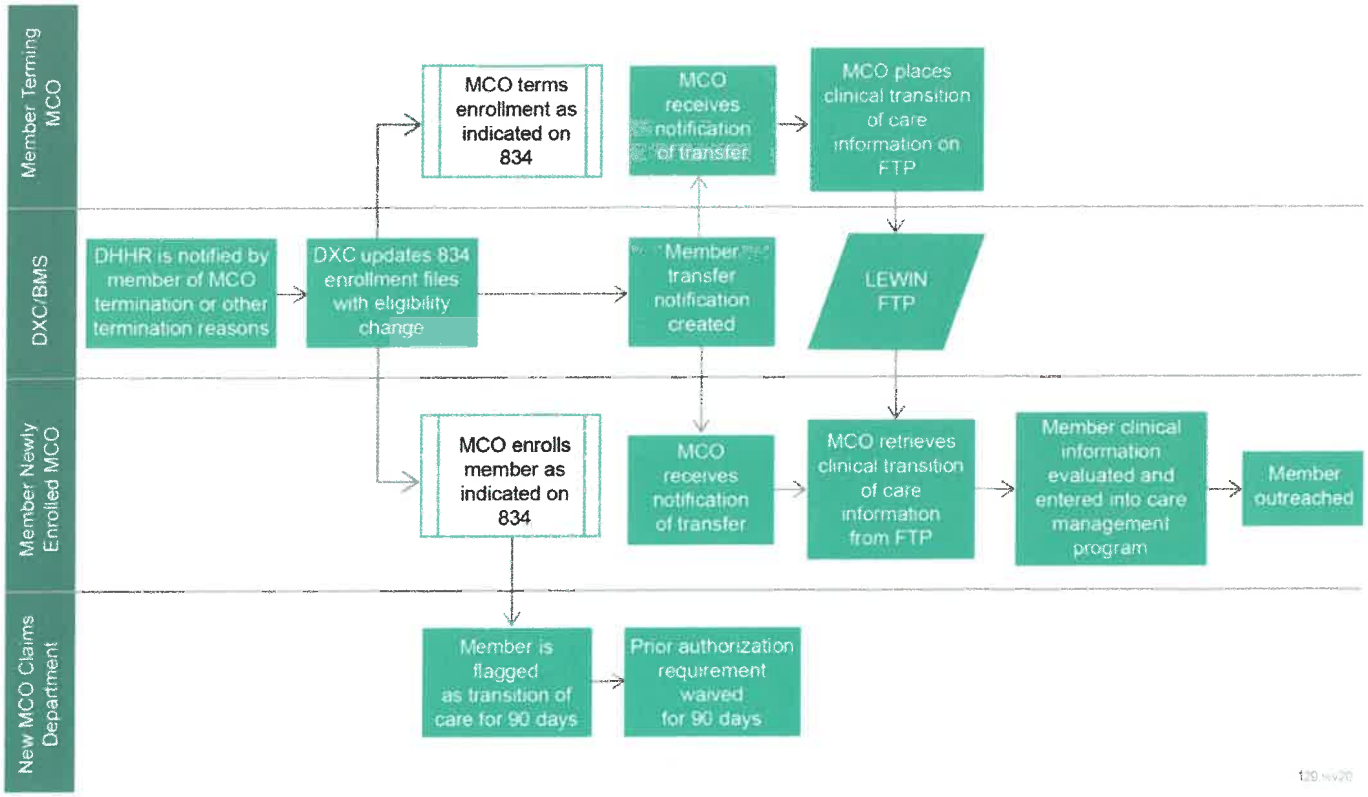


Figure 6.6.1-8: Member Transition of Care

We actively work with all enrollees who want to disenroll from our plan to maintain their continuity of care and to ensure their health and health care needs are met while they transition to a new plan.

Member Disenrollment Request Process

Aetna advises our members that disenrollment requests must be submitted orally to the Department. Our Member Services staff facilitates a warm transfer between the member and the Department. Additionally, we understand that the Department is solely responsible for disenrolling members, and a disenrollment request will become effective on the first day of the next month following the member's disenrollment request. Aetna's Enrollment Services department runs a monthly report of retro-disenrolled members, capturing any claims paid data, and we forward this detail to our Claims department for possible recoupment.

To further provide validity and accuracy of membership, we generate an out-of-area audit report, which uses data from our core information system. Our Enrollment staff follow a set of

documented procedures to review the report and identify members with an address that is located outside the defined service area. We also receive notifications from internal supporting departments when a member has been identified as deceased or incarcerated.

We track member nursing home stays through our electronic care management system. Our Care Management team notifies our Enrollment Services department of members who have resided in a nursing facility for more than 30 days. We also notify the Department about members who are projected to reside in a nursing facility for more than ninety days.

With each notification or identified member, our Enrollment staff investigates the enrollment scenario to ensure accuracy of the disenrollment information using our utilization management documentation, the Department eligibility website/portal, and previous 834 file data received from the Department. We also validate that the Department does not already have the disenrollment data on file to prevent duplicate notifications to the Department.

Exhaustion of Benefits

Whenever an Aetna enrollee who is eligible for certain programs, such as WVCHIP, exhausts the allotted services as defined in the state regulatory agency's benefit plan, Aetna is responsible for informing the applicable state regulatory agency or client in accordance with regulatory or contractual requirements. Aetna is responsible for providing information regarding alternative care and resources which are available to the member, if applicable.

Coordinating Member Care during a Membership Transition

We recognize that a change in a service model can be challenging and we focus our efforts on providing a seamless transition for Mountain Health Trust, West Virginia Health Bridge, and WVCHIP members as they transition to managed care and/or between MCOs. Transitioning between managed care organizations requires a well thought-out and prepared approach,

including pre-defined processes for data transfer between MCOs that include a data dictionary, file layout, and file transfer timing guidance from the Department. Our member transition policy supports the smooth transfer of information and continuation of the member's care. When transitioning members, our procedure requires our Member Services, Care Management, and Enrollment Services departments to collaborate and perform the following activities:

- Review and update the member's care plans to address the member's special health care needs.
- Determine the member's immediate needs by conducting condition-specific assessments and coordinating all necessary Medicaid and non-covered services.
- Identify and confirm the providers and organizations from which the enrollee is receiving services.
- Contact the health care and service providers to do the following:
  - Confirm the provider's awareness of the transition
  - Identify barriers to a successful transition
  - Advise the provider of transition requirements
  - Initiate and facilitate the transfer of applicable medical records
  - Identify new or urgent health care/service needs
  - Initiate service authorizations that may be required for a particular service. Send service authorization letters as appropriate to the provider.
  - Initiate letters of agreement that may be needed for non-participating providers. Refer non-participating providers to our Provider Relations team for loading into the business application system for payment, when applicable.
  - Reference applicable letters of agreement with waiver programs or out-of-plan services to ensure the member transition process is managed per the agreement(s).
- Monitor continuity and quality of care, transition activities, services, and reporting for each member.
- When transitioning a new member into our plan, we collaborate with our member services director and department to obtain prior authorization files and service plans from the previous health plan so that all services and supports, including access to prescriptions, can continue for up to six months after the transfer, or until the end of the current authorization period, or until a new assessment is completed (within 90 days of enrollment) and a new service plan is authorized.
- We contact the member to make sure they are aware of the transition and to verify the status of current care and prescription authorizations.

Transfer of Medical Records

Practitioners are responsible for making enrollee records available to health plans to which members are transferring and/or to other practitioners upon request, and in compliance with confidentiality requirements of Aetna and HIPAA, 42 CFR Part 2 and all federal and state

regulations. At a minimum, practitioners are requested to transmit medical records related to diagnostic tests and determinations in the past sixty days, current treatment services, all immunization and EPSDT records, hospital discharge summaries within the past year, current medications list, specialist referrals with in the past sixty days, behavioral health quarterly summaries, and emergency care summaries.

Aetna facilitates the transfer of pertinent medical records (as needed) and transfers other requested records that exceed the requirements of the policy if so directed or required by the Department.

7. Network Development

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Network Development (ND) as part of their bid. The Vendor's narrative response should not exceed 50 pages.

In support of our commitment to serving West Virginia, Aetna offers a robust and established statewide physical health, behavioral health, dental, vision, specialty care, and publicly supported provider network that serves all counties in the state to support the Department for Health and Human Resources (Department) goal to ensure access to Mountain Health Trust (MHT), West Virginia Health Bridge (WVHB), and West Virginia Child Health Insurance Program (WVCHIP) members.

Establishing and Maintaining a Provider Network

ND001	The Vendor should describe how they will establish and maintain a provider network that provides statewide access to geographically accessible hospitals, primary care, specialty care, dental providers, and all other required provider types.
ND002	The Vendor should describe how they will establish and maintain a network accessible, contracted, and credentialed provider for al covered services including supplemental services such as value-add services for, or on behalf of MHT members.

Aetna has contracts with approximately 11,000 providers, including more than 1,406 primary care providers (PCPs), 7,152 specialty physicians, 736 behavioral health specialists, and all 72 West Virginia federally qualified health centers (FQHCs) and rural health clinics (RHCs).

Aetna was recently awarded the West Virginia Mountain Health Promise contract and has been contracting with additional providers to serve these vulnerable children. Also, in anticipation of serving WVCHIP members, we have identified that the majority of our Medicaid network providers are also serving WVCHIP members. We identified the providers from the state provider list who are not contracted with us. We have contacted those providers serving WVCHIP members who are currently out-of-network and we have invited these providers to join

our network. Our team contacts the providers by telephone about their interest in contracting with us and then follows up the call with an email that contains the contract. Our Network Development and Provider Relations teams work together and continually strive to exceed network requirements in all regions. The key elements of our network strategy include the following: demonstrating compliance with network adequacy and provider accessibility requirements throughout the state; continuing to enhance our network of high-quality, member-focused providers; offering a comprehensive network to maximize member choice and accessibility; and integrating network development activities with clinical practice models.

Our West Virginia network currently serves approximately 138,000 West Virginia Medicaid members. To ensure all health care is available, our locally based Network Development and Provider Relations teams work collaboratively with providers, community stakeholders, and advocacy groups to ensure that covered services are accessible, person-centered, and evidence-based, and span the full spectrum of services needed.

[ND001] Statewide and Geographically Accessible Provider Network

Aetna's statewide, comprehensive network complies with state availability and access standards identified in Model Service Provider Agreement, Section 2.1.2 Access and Availability Standards and Appendix J.

Establishing and Maintaining a Network with Statewide Access

Aetna has an established and open network to service MHT and WVHB members. As most of the WVCHIP members are currently seeing providers within our network, we have already begun our outreach and contracting process for those WVCHIP providers not contracted with us. We continually work to make sure our network meets adequacy to fully serve member populations and it is scalable to meet the needs of the WVCHIP members upon implementation.

To maintain and grow our West Virginia statewide network, Aetna's network development director identifies network gaps and opportunities for improving member access to services. The network development director and provider relations director continuously review network adequacy data, both prior to an award and ongoing after award, to identify opportunities for network growth and maintenance and review the status of recruitment plans. Our recruitment efforts do not end when network adequacy is met; it is a continuous process to monitor and grow our network to enhance quality and meet the needs of our members. The network development director and provider relations director also review network adequacy data to identify opportunities for network enhancement and growth and review the status of the recruitment plan. They also monitor provider compliance with required time, distance, and appointment wait time standards under the MHT, WVHB, and WVCHIP programs.

We employ ongoing maintenance strategies to maintain our provider relationships and to ensure the special needs of our members are met. Upon notice of a potential issue or shortage from the integrated care team or other community organizations, they conduct research and outreach.

Recruitment efforts include utilizing the following sources of information to identify providers:

- Review of provider enrollment files (PROV 12 file) from the Department for new providers in the market
- Examine emergency room (ER) utilization and non-participating providers within proximity to highly utilized ERs to target for recruitment
- Review Member Services feedback that includes members calling in with provider requests and Provider Services call center feedback
- Review single-case agreements for opportunities to contract with non-participating providers
- Work with local West Virginia provider organizations, as well as national and regional health organizations, to identify providers, including the following:
  - Behavioral Health Provider Association
  - National Association of Social Workers—West Virginia Chapter
  - West Virginia Primary Care Association
  - West Virginia Hospital Association
  - Healthy Kids Coalition

  - School Based Health Assembly
  - West Virginia Osteopathic Medical Association
  - West Virginia Healthcare Association
  - West Virginia Board of Medicine
  - West Virginia State Medical Association
  - West Virginia Partners in Health
- Consider member and/or provider referrals of potential providers
- Utilize quarterly monitoring, which triggers recruitment action as we review geographical mapping reports
- Evaluate current and projected population demographic needs, as well as anticipating cultural and health disparities
- Review analysis of geographical mapping reports during our Quality Management/Utilization Management Committee meetings
- Invite provider participation and input on future network needs through our Member Advisory Committees, plus participation in provider association meetings including the Primary Care Association and Joint Operating Committee meetings
- Develop opportunities for participation and feedback through our Aetna Medicaid National Advisory Council, which includes West Virginia providers, stakeholder collaborations, and meetings comprised of health care professionals, advocates, and members to discuss issues, including network adequacy and recruitment priorities for growing the network
- Obtain stakeholder feedback on network composition, operations, and quality improvement initiatives to make sure we meet the cultural needs of the community and assess any areas of concern
- **Invite provider participation in a variety of educational forums and webinars to share ideas, questions, and concerns, as well as future network needs/projections**
- Seek feedback, suggestions, and innovative ideas from providers to offer better access and increase member convenience, including a review of Consumer Assessment of Healthcare Provider and Systems (CAHPS) and provider satisfaction survey results

Once we identify a provider gap, our Provider Relations team contacts potential providers by telephone about interest in contracting with us and then follows up with an email that contains the contract. Once the provider identifies that they want to join our network, our dedicated West Virginia Credentialing staff assists providers with the process to streamline the credentialing and contracting process, reducing burden on the provider. This dedicated West Virginia Credentialing staff understands that the credentialing process can be cumbersome and therefore helps West Virginia providers through the administrative processes to eliminate duplicative efforts. In addition, if a provider is completing the credentialing and contracting

process with Aetna and has members who need to be seen, we will work with the authorization teams to make sure the members get the care they need while the provider is being processed.

We are continuously expanding upon our existing, extensive, and experienced West Virginia provider network to deliver high-quality medical, behavioral, dental, and vision services to our members. Aetna's provider network offers statewide access as represented in **Table 6.7.1-1.**

Table 6.7.1-1: Aetna Provider Network Adequacy and Accessibility

Provider Type	Number of Available Practitioners based on Time and Distance Standards	Availability 2019
Primary Care Providers		
Internal Medicine	152	99.9%
Family Practice/General Practice	472	100%
Pediatrics	255	100%
Nurse Practitioners	352	100%
High-volume Specialists		
Obstetrics and Gynecology (OB/GYN)	315	99.8%
Otolaryngology/Ear, Nose, and Throat	126	87.7%
Ophthalmology/Optometry	394	99%
General Surgery	303	99.7%
High-impact Specialty		
Oncology	122	100%
Other Frequently Used Specialties		
Allergy	36	98.6%
Audiology	79	100%
Cardiology	278	100%
Chiropractic	175	100%
Dermatology	46	99.8%
Durable Medical Equipment	330	99.4%

Provider Type	Number of Available Practitioners based on Time and Distance Standards	Availability 2019
Endocrinology	57	99.3%
Gastroenterology	130	100%
Hematology	102	100%
Home IV Therapy	13	99.8%
Neurology	182	100%
Neurosurgery	61	94.5%
Nephrology	79	100%
Orthopedics	221	97.8%
Orthotics and Prosthetics	43	99.9%
Physical Therapy	191	100%
Plastic Surgery	39	90.6%
Podiatry	112	100%
Pulmonology	89	100%
Speech Therapy	22	99.6%
Thoracic Surgery	66	99.4%
Urology	98	100%
Hospitals—Basic Services	73	100%
Hospitals—Tertiary Services	36	96.5%
Behavioral Health Providers		
Psychologists	209	100%
Psychiatrists	180	100%
Licensed Professional Counselor	149	100%
Licensed Independent Clinical Social Worker	150	100%
Behavioral Health Facilities (Inpatient Psychiatric and Psychiatric Residential Treatment Facility [PRTF])	29	95.6%
Substance Use Disorder (SUD) Providers	122	100%
SUD Facilities	19	100%

Provider Type	Number of Available Practitioners based on Time and Distance Standards	Availability 2019
SUD Residential Provider (Serious Emotional Disturbance Waiver Services)	19	100%
Dental Providers		
Adult Dentistry (open network—Aetna is billed for this service)	N/A	N/A
Pediatric Dentistry	534	100%
Vision Providers		
Vision Providers	221	96.7%

Publicly Supported Providers

Aetna has an established robust network of publicly supported providers as outlined in Model Service Provider Agreement, Article III Statement of Work, Section 2.4 (2.4.1-2.4.9) Publicly Supported Providers and the number of Aetna contracted providers. **FQHCs and RHCs:** Aetna contracts with 72 FQHCs and RHCs, and we have long-term relationships with West Virginia FQHCs and RHCs. We collaborate with them for wellness and dental events to improve member access and education. For example, we collaborated with FQHCs and RHCs in 2019 to conduct 24 wellness events that included well-child exams, children's dental exams, well-women exams, and diabetes testing and screening. **We also aided FQHCs to purchase two retinal cameras.**

Local Health Departments (LHDs): We are currently contracted with 44 LHDS, 86 percent of the LHDs in the state. We will continue our outreach to the remaining LHDs. We collaborate with LHDs to offer influenza vaccination campaigns, such as a recent influenza vaccination clinic event collaborating with **Kanawha-Charleston Health Department**. We will also continue to promote vaccines for childhood immunizations through the State Bureau for Public Health's

Immunization Program by encouraging providers to refer their patients to these programs. Aetna understands that environmental lead assessments for our enrolled Medicaid children with elevated blood levels will be reimbursed directly by the State Bureau for Public Health and that we are responsible for the blood lead screenings.

Critical Access Hospitals (CAHs): Aetna currently has contracts with all 25 CAHs throughout the state for inpatient and outpatient hospital services in very rural areas of the state.

State-designated Primary Care Centers: Through our contracts with 72 FQHCs and RHCs, we provide members access to state-designated primary centers, enabling members to receive services in the areas where they live.

School-based Health Clinics (SBHCs): Aetna contacts with more than 156 SBHCs. As West Virginia has the largest saturation of SBHCs in the nation, we understand the importance of these clinics to provide general, primary health care services to school-aged children. Aetna also recognizes these centers as increasingly important providers of primary health care, especially in rural communities which face shortages of PCPs.

Right from the Start Providers (RFTS): RFTS is a West Virginia State program aimed at improving early access to prenatal care, lowering infant mortality, and improving pregnancy outcomes. We currently have 26 RFTS providers in our network.

Bureau of Public Health (BPH) Laboratories: We are reaching out to the BPH laboratory to contract with us. We will comply with requirements related to the use of BPH laboratories for specified cases and requirements for BHP laboratories to perform tests, including those mentioned under core services, on members for public health purposes. We will also require contracted laboratories with positive findings of certain reportable diseases under the

Reportable Disease Rule in category I, II, and IV (the list of reportable diseases is available from the Department) to submit an isolated serum specimen or other designated material to the Office of Laboratory Services (OLS) for confirmation or other testing needed for epidemiological surveillance. However, whenever a service is not funded by other state or federal funds, Aetna will reimburse OLS for these services.

Children with Special Health Care Needs (CSHCN) Providers: Aetna currently has 633 CSHCN providers contracted in our network and we are in the process of contracting additional CSHCN providers for our membership. By contracting with CSHCN providers, we will enable children and youth with special health care needs to receive a patient/family-centered medical home approach to comprehensive, coordinated services and supports.

Indian Health Providers: Aetna will follow the requirements related to Indians, Indian Health Care Providers, and Indian Managed Care Entities according to 42 CFR 438.14.

We endeavor to contract with all publicly funded providers. We will comply with requirements to develop and implement a strategy to ensure members in the region have access to all covered services and to make payments to non-contracted, publicly supported providers as required and detailed in the Model Service Provider Agreement, Article III Statement of Work, Section 2.4.

Additional Provider Types Enhance our Network

Aetna continually evaluates the network to address the needs of our members. We have contracted with opioid treatment centers and will continue contracting efforts to address the opioid dependence epidemic in the state. We will also contract with Medical Home Providers who serve the WVCHIP population and have also contracted with all applied behavioral analysis providers in the state.

Opioid Treatment Centers

Aetna has contracted with opioid treatment centers in West Virginia and will continue contracting efforts to meet member needs and reduce the adverse impact of opioid use on members and families. **We are currently contracted with 100 percent of SUD residential providers in the West Virginia.** Aetna is committed to enhancing access to evidence-based treatment options for our members such as medication-assisted treatment (MAT). We are collaborating with providers to increase adoption of MAT by providing education, technical support, and promoting adoption through value-based contracting and the recognition of quality MAT providers.

In addition, Aetna provides financial support to the **Provider Response Organization for Addiction Care and Treatment** (PROACT), a large community-based organization in Huntington that offers MAT/SUD treatment, peer support, job placement, and referrals to other services. We also engage the services of Lily's Place. **Lily's Place**, located in Huntington (Cabell County), was the first neonatal abstinence syndrome (NAS) center in the nation.

We understand that, frequently, a history of trauma can be the root cause of a member's presentation with SUD or opioid use disorder. As a result, we have implemented a trauma-informed care (TIC) training program for our providers.

Medical Home Providers

Aetna will contract with all qualified WVCHIP designated medical home providers, and we will work with them to enable WVCHIP members to have choices for a medical home. Aetna will encourage WVCHIP members to select a medical home from a list of enrolled providers who have elected to participate in the Medical Home Program, and must be PCPs in the areas of pediatrics, general or family medicine, or internal medicine. By selecting a medical home

provider, WVCHIP members will reduce their costs by eliminating copays for sick visits (there are no copays for preventive visits).

Applied Behavioral Analysis (ABA) Providers
We have recently contracted with most applied behavioral analysis (ABA) providers in the state to serve children with autism or Asperger's syndrome. We are continuing our efforts to contract with all ABA providers. This evidence-based approach to treatment focuses on social skills, communication, reading, and academics as well as adaptive learning skills, fine motor dexterity, hygiene, grooming, domestic capabilities, punctuality, and job competence.

[ND002] Providers for all Covered Services
Aetna currently has a credentialed network capable of a full array of services as detailed in Model Service Provider Agreement, Section 2.1.1. and Appendix A. Our supplemental/value-added services include special dental services for members who are pregnant or have diabetes, for which we have an established dental network.

As identified earlier in this response, **our locally based Network Development and Provider Relations staff collaborate with providers, community stakeholders, and advocacy groups to ensure that covered services are accessible, person-centered, evidence-based, and span the full spectrum of services needed.** Additionally, our Network Development team establishes our provider network, negotiates contracts, and makes certain of our network adequacy and accessibility across West Virginia to meet the needs of MHT, WVHB, and WVCHIP members. The Network Development team also monitors counties, cities, and towns where a gap in our network might occur, or where a critical specialty could be underrepresented, and additional providers are needed. These monitoring efforts serve to prevent a gap in care delivery and ensure disruptions do not affect member access to care.

Aetna is continuing to expand our existing provider network to deepen and broaden access to primary and specialty care providers, hospitals, clinics, home health and hospice care providers, medical home and CSHCN providers, and other key providers from the behavioral health system. **We strongly agree and share in the state's vision for member access to high-quality health care across the continuum of services.**

To demonstrate our commitment of a robust system of providers that afford member choice, we develop and make available our Physical Health and Behavioral Provider Recruitment Plan that focuses on accountability and transparency in our network development policies and procedures, as well as strategies and communications that impact our provider network.

Network Development and Monitoring Processes to Ensure Adequacy

ND003	The Vendor should describe how they will establish network development and monitoring Processes that ensure adequacy of covered services and includes the following considerations, including, but not limited to, the following:
ND004	The anticipated MHT enrollment and the appropriate PCP provider-to-member ratios for adult and pediatric members
ND005	The expected utilization of services for the anticipated MHT populations assigned to the Vendor for care
ND006	The number of providers not accepting new patients
ND007	The geographic location of providers and members, considering time and distance, and transportation needs
ND008	The location of providers with physical access accommodations for members with disabilities and/or other requirements set forth under the Americans with Disabilities Act (ADA)

We continuously work on network development and monitoring to make sure providers are available at the right location within the appropriate timeframe to meet the needs of West Virginians with statewide access to services.

[ND003] Development and Monitoring to Ensure Adequacy of Covered Services

To maintain network adequacy and accessibility to care, as well as to identify gaps in network access or where gaps are prone to occur, Aetna conducts both member density and network

geographical mapping analysis to pinpoint areas within the state, within counties, and deeply into each city where network adequacy and provider accessibility can be enhanced. We carefully evaluate the numbers of providers and the related time and travel distance to reach a provider, appointment availability, after-hours access, open panel status, and cultural competency for key provider types.

Network Adequacy Efforts to Improve Member Access

Our analytics show that acute care and children's hospitals, behavioral health practitioners, and certain specialists are the most likely areas for network gaps. We understand the difficulties members may have accessing specialist providers and we have therefore built a Care Connections team model to assist members receive the care they need within their home communities. **Care Connections teams co-locate with providers in every region of the state and have relationships with provider and community service agencies to support identifying and resolving potential network gaps**.

Aetna uses assessment and measurement tools, such as geographical mapping, the Network Adequacy Report, and the State PROV12 report, as the primary means of demonstrating achievement of network adequacy compliance with West Virginia provider network access requirements and expectations. We apply the Department's provider network standards to assess travel time and distance for members to access essential and specialty providers. Through our contracts with all the FQHCs and RHCs in West Virginia, we comply with requirements to have as many FQHCs and RHCs as necessary to permit member access without having to travel a significantly greater distance.

Single-case Agreements for Non-participating Providers
If a qualified provider is available outside of the network (possibly in a bordering state) for a specialized covered service, we will either contract with that provider or allow the member to seek services from that non-participating provider using a single-case agreement (SCA). We coordinate payment to non-participating providers, making certain the cost to the member is not greater than it would be if the service were provided in-network. Our Provider Relations team engages and encourages non-participating providers to join our network.

Border State Providers
The Aetna Medicaid organization has health plans in all five of West Virginia's border states. We routinely leverage the established provider relationships of these health plans to establish agreements with border state providers. Access to border state providers improves access to specialty providers and reduces member travel time because some border state providers are located closer to our West Virginia members than in-state providers. We currently have letters of agreement or contracts with a variety of border-state providers including the following;

- Cincinnati Children's Hospital in Ohio
- University of Kentucky's facilities and physicians
- Winchester Medical Center in Virginia
- Pikeville Medical Center in Kentucky
- Big Sandy in Virginia
- Western Maryland Health Systems

Addressing Service Gaps in Rural Areas and for Specialty Providers
Based on our knowledge and experience working in West Virginia, there are two counties, Pendleton and Pocahontas, that have the most significant challenges with provider accessibility. Both counties present challenges related to specialty providers including otolaryngology, ophthalmology, general surgery, endocrinology, home intravenous therapy, neurosurgery, plastic surgery, and thoracic surgery.

We also understand that West Virginia's mountain culture and geography can present a distinct access to care barrier for our members who live in remote mountain regions. To best serve remote mountain members, especially members without access to telephone or internet, we are collaborating with an FQHC with locations across the southern part of the state, including Boone and Kanawha, to provide mobile medical and dental screening services. This collaboration includes offering physical health and dental services via mobile van units that will offer services such as preventive well woman and well child visits as well as dental screenings. We will continue to work closely with FQHCs and LHDs to sponsor member engagement events, such as dental services and flu vaccination events. We will work to coordinate events with the **West Virginia University Cancer Institute Bonnie Bus**, which provides mobile mammograms throughout the state. Additionally, our Care Connections team will work with members to connect with transportation vendors in rural areas using the West Virginia Department of Transportation website. The site has contact numbers for transportation vendors in each county. For example, in Pendleton County, **Potomac Valley Transit Authority** provides public transportation for individuals living in the county.

Telehealth Services Expand Access for Rural Areas

We are committed to the advancement of telehealth in the state. At this time, telehealth is an underutilized tool that could be used to mitigate limited access to services in rural areas of the state and transportation issues with having to travel to one of the three major medical centers. **Currently, our local behavioral health medical director and clinical liaison are participating on the state's telehealth policy panel.** We look forward to finding creative solutions to improve access to care, not just for our members but all residents of the State.

We currently collaborate with **West Virginia University** (WVU) through the WVU PALS program, a telepsychiatry program that enables PCPs to consult with a psychiatrist about the care and management of children and adolescents. We provided WVU a $50,000 grant to assist with start-up. This program is promising because West Virginia has a shortage of psychiatrists and often the PCP manages psychotropic medication, educates parents/guardians, and works with therapists and other outpatient providers. We also collaborate with Anytime Pediatrics and Nationwide to provide telehealth for pediatric oncology patients.

Telehealth to Supplement Traditional Service Delivery

We will use a range of telehealth services as an alternative to or to complement traditional service delivery. Consistent with State regulations, specific clinical services will be offered in authorized originating sites. Telehealth services will be delivered in real time, through interactive live audio video technology offered by allowable provider types. We will also support the use of telehealth by our in-network providers using their own approved technology or given the opportunity to utilize a plan-sponsored technology platform to enhance access to their members via telehealth. Alternatively, if indicated, we will use preferred West Virginia-licensed vendor telehealth practitioners, as per West Virginia State regulations, to meet both the physical and behavioral health needs of our members using evidence-based protocols. Telehealth has been proven to improve care treatment compliance, decrease both emergency room (ER) and inpatient hospitalization utilization, reduce disease burden in communities, and promote the concurrent use of advanced specialty capabilities in coordination with a member's local PCP. In addition, **available telehealth services promote the integration of physical and behavioral health care and enable provider-to-provider consultation between PCPs and specialists, enhancing coordination of care and access to services**.

Addressing Specialty Service Gaps

We are well-positioned to proactively identify and respond to likely gaps and solutions to make sure member needs are met. For example, in August 2019, we contracted with **River Park Hospital**, a behavioral health facility located in Cabell County, which offers inpatient and PRTF services. We also contracted with **Logan-Mingo Area Mental Health**, which is in the state's southern region and is the only provider of behavioral health/medically assisted treatment in the area. In addition, we contracted with **Neurological Associates**, a large neurosurgery and orthopedic surgery practice in Kanawha County.

We continue to collaborate with associations, community organizations, hospitals, and academic organizations for new providers entering the area, or to develop relationships to meet specific needs, such as providing telehealth or community solutions to maintain and increase network accessibility, especially in the identified geographic areas and scarce provider specialties.

These collaborations include the following organizations:

- Behavioral Health Provider Association
- National Association of Social Workers—West Virginia Chapter
- West Virginia Primary Care Association
- West Virginia Hospital Association
- Healthy Kids Coalition
- School Based Health Assembly
- West Virginia Osteopathic Medical Association
- West Virginia Healthcare Association
- West Virginia Board of Medicine
- West Virginia State Medical Association
- West Virginia Partners in Health

In addition, our Care Connections teams are co-located with providers in every region and assist us in identifying and resolving potential gaps in network accessibility.

Monitoring Process

We monitor our network to make certain that every member has access to services that support the need to achieve their health ambitions. Our goal is to exceed West Virginia's requirements by providing access and choice of providers, including essential and specialty providers, to 100 percent of members within the required time and distance standards. While the provider counts in this section reflect our current network, we continue to build network capacity to eliminate identified access challenges or deficiencies. We will leverage our current assessment tools, and will include methods detailed in **Table 6.7.1-2** below:

Table 6.7.1-2: Network Monitoring Data and Reports

Reporting and Monitoring Activity	Data or Report Description
Geographical Mapping Reports	We review geographical mapping to measure compliance with the Department's access standard requirement for each ZIP code
PCP-to-Member Ratios	We review ratios by provider type and region to confirm availability of an adequate number of PCPs **[ND004]**
Network Adequacy	We review utilization data including prevalent conditions, SCAs, provider referral issues (availability of specialties), providers-gained-and-lost report, and unplanned network exit report to confirm sufficiency of the type and number of providers **[ND005]**
Emergency Room Utilization Dashboards	Continuous monitoring is performed using operational dashboards that measure and trend member utilization, including ER care. These dashboards allow us to identify opportunities to enhance our network by location, disease state, and member type. **[ND005]**
Network Panel Studies	Network panel studies are performed, using the open/closed panel report, to assist in assessing network access and availability needs and identify providers who have reached their capacity **[ND006]**
Provider Directory Audits	These audits confirm the accuracy of provider listings and are used to make weekly updates to online directories, including changes in demographics and panel status **[ND006]**
Provider Appointment Availability Phone Surveys	To improve monitoring of access for the population served under this contract, we will query providers on appointment availability, open scheduling, and after-hours care **[ND006]**

Reporting and Monitoring Activity	Data or Report Description
Interdepartmental Reporting	Our formal interdepartmental process allows the Provider Relations department to collect, trend, and respond to network needs our staff may identify outside other data and reporting
Call Center Encounters Data	Our call center collects information regarding member calls about network provider availability and access, and shares the call information with the Provider Relations team to assess potential network gaps, barriers, and opportunities for network development
Member and Provider Appeal and Grievance Data	We review analysis and trending of appeal and grievance cases to identify availability or accessibility issues, perform root-cause analysis, and develop corrective action plans (CAPs), if necessary
Provider Satisfaction Surveys	We review and analyze provider satisfaction survey results and create action plans for improvement identified through the survey
CAHPS survey	We review and analyze CAHPS survey results and create action plans for improvement identified through the survey

Aetna evaluates projected adult and pediatric population needs statewide against the current contracted provider network to identify any opportunities to recruit services and providers.

[ND004] Appropriate PCP Provider to Member Ratios for Adult and Pediatric Members.

Aetna's current network meets the provider ratios as outlined in the Model Provider Services Agreement, Article III Statement of Work, Section 2.2.2 Ratio of PCPs to Enrollees, and the ratio of PCPs to members meets or exceeds the required ratio of 1 PCP for every 500 adult members who is accepting new patients and 1 age-appropriate PCP for every 250 pediatric members under 21 who is accepting new patients. We do not propose any modification to the existing provider ratios, even with the inclusion of the WVCHIP members. We will continue to monitor member access and will communicate any new revelations to the State.

[ND005] Expected Utilization of Services for the Anticipated MHT Populations

We review current and historical utilization data including prevalent conditions, SCAs, provider referral issues (availability of specialties), the providers-gained-and-lost report, and the

unplanned network exit report to confirm sufficiency and capacity of the type and number of providers. We also continuously monitor our operational dashboards that measure and trend member utilization including ER care, enabling us to identify opportunities to enhance our network by location, disease state, and member type.

[ND006] The Number of Providers not Accepting New Patients

We identify the number of providers not accepting new patients using various methods. We perform network panel studies, using the provider panel size report, to assist in assessing network access and availability needs and identify providers who have reached their capacity. We update our systems if a provider's panel is full, so we do not manually or automatically assign a new member. We also audit our provider directory for weekly updates including changes in panel status and update the directory. We also conduct annual provider appointment availability surveys using email and fax.

[ND007] The Geographic Location of Providers and Members, Considering Time and Distance, and Transportation Needs

We continually evaluate reports, including geographical mapping and network adequacy information, to determine where we need to increase the number and type of new providers to the network as well as appropriately prepare for anticipated network providers across the service area. Geographical mapping reports are generated at least annually, and more often as necessary (e.g., with added membership, such as the Mountain Health Promise membership), and the report is then reviewed by health plan and network leadership. We also use interdepartmental reporting that allows the Provider Relations department to collect, trend, and respond to network needs. Our staff may also identify network challenges from feedback from our care coordinators or informal discussions with community organizations, and information collected by our call center about network provider availability and access. We analyze and

trend member and provider appeal and grievance data to identify potential availability or accessibility issues, perform root-cause analysis, and develop CAPs, as necessary. CAHPS survey results also provide data indicating opportunities for improvement.

Transportation assistance can be provided to members by calling our Member Services call center to connect them with LogistiCare, the transportation vendor in the state. Our Member Services staff will warm transfer the call to LogistiCare while staying on the line with the member. Our care coordinators and community health workers also work closely with members to ensure they have transportation when needed to see a provider through ride share programs, the West Virginia Department of Transportation website resources, and LogistiCare. We recognize that lack of sufficient transportation is a potential barrier that keeps members from seeking care in some geographic locations.

[ND008] The Location of Providers with Physical Access Accommodations

Aetna employs several approaches to determine a provider's compliance with Americans with Disabilities Act (ADA) standards for physical accessibility and reasonable accommodations including parking, exam and waiting rooms, and accessible equipment for Medicaid members with physical or mental disabilities. We emphasize identification of providers with key accessibility to care opportunities such as providing oversize exam tables, specialized staff assistance for members with needed care requirements, or materials in braille to serve the varied member health care needs. We assess compliance with ADA standards during onsite visits, through credentialing and re-credentialing processes, monitoring member complaints, and while gathering information used in our provider directory, such as physical accessibility and accommodations. These indicators are available across all provider types, including behavioral health, home health, nursing care, and home- and community-based providers to help make

sure the member selects the right provider. We have a process in place where all potential findings related to member quality of care concern are reported and investigated.

Cultural Competency

ND009	The Vendor should describe how they ensure its provider network will provide culturally competent care to members.

Cultural competency and health literacy are at the core of our service delivery. Aetna's health care equity director prepares a detailed Cultural Competency Plan (CCP) annually to ensure engagement of all health plan leaders and alignment with Culturally and Linguistically Appropriate Services (CLAS) standards and to ensure compliance. The CCP outlines the processes used to develop and maintain a culturally competent staff and provider network. This plan includes strategies designed to integrating cultural and linguistic competence and health literacy into every aspect of our organization.

[ND009] Ensuring our Provider Network Provides Culturally Competent Care

We realize that a critical element to providing quality service involves developing and maintaining culturally appropriate services that address diverse cultural and ethnic backgrounds, disabilities—regardless of gender, sexual orientation, or gender identity—and provide for cultural competency and linguistic needs, including the member prevalent language(s) and sign language interpreters. Aetna utilizes the U.S. Department of Health and Human Services (DHHS) Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care and follows from DHHS, A Blueprint for Advancing and Sustaining CLAS Policy and Practice, to inform the annual revision of our policies.

Aetna provides inclusive care to a diverse population in West Virginia. Aetna policies and training requirements reflect the commitment of member-centered care that is responsive to the unique needs found in West Virginia. Our CCP focuses on effective and equitable care and

services by respecting and honoring each member's cultural health beliefs, practices, preferred language, special needs, and socioeconomic background. In addition to standard provider training and education regarding meeting member cultural needs, we will work with our providers to educate them on an expanded view of culture to include socioeconomic factors, local community variances, and family dynamics.

Cultural Competency Provider Training

Our approach to meeting the linguistic and cultural needs of our members includes the provision of cultural competency training to providers, continuous assessment of member demographics to best understand language and interpreter needs, and the development of innovative provider collaborations to serve members locally. Our providers should confirm all services, both clinical and non-clinical, are provided in a culturally and linguistically competent manner and are accessible to all members. They should verify that members receive understandable, respectful, and timely care that is compatible with their cultural health beliefs, practices, and preferred languages from all provider staff members. Providers receive education during orientation and on an ongoing basis about such important topics as the following:

- The reluctance of certain cultures to discuss mental health issues and the need to proactively encourage members from such backgrounds to seek needed services
- The impact that a member's religious and/or cultural beliefs can have on health outcomes
- The problem of health illiteracy and the need to provide patients with understandable health information (e.g., simple diagrams, communicating in the vernacular)
- The progression of civil rights for people with disabilities
- Physical and programmatic barriers that impact people with disabilities accessing care
- Provider obligations for delivering culturally competent care
- Resources such as Unite Us and Aunt Bertha, an online repository of community services
- Social determinants of health and trauma-informed care
- Training staff on the need to understand and respect cultural differences and developing services that better meet the needs of minority populations and remove barriers to care
- Assisting members with limited English proficiency
- Providing access to interpretive and American Sign Language services for members

- Assessing feedback from members about programs, quality initiatives, member materials, and other education and outreach tools to meet their cultural and linguistic needs

We continually monitor our member demographics to better understand the individuals we serve. For example, in Beckley and Bluefield, 20-25 percent of our members are African American. Because of our regional approach to services, our care coordinators become familiar with populations in their regions, and our System of Care staff and Provider Relations staff work with providers to ensure these members receive culturally competent care. We understand that religious and cultural beliefs in African American culture are important to consider, such as lack of trust in the health care providers and the system—there are also beliefs such as "we trust individuals most like us"; fear that surgery may cause cancer to spread; and apprehension in using opioids for pain management for fear of addiction. Older adults may seek treatment from home remedies, prayer, spiritual healers, and advice from family and friends; a lack of spiritual imbalance may be seen as any physical, mental, acute, or chronic disease.

Additionally, West Virginia ranks highest in the nation for children aged 13 to 17 who are transgender. To best address the needs of lesbian, gay, bisexual, transgender, and queer-identifying (LGBTQ) members, our care coordinators and providers receive training and experience working with this population to have a robust understanding of the cultural values and practices within the community to address discrimination at both an individual and system level and to ensure that providers understand proper language is essential, such as using correct identifying pronouns. Training also emphasizes the importance of strict confidentiality practices, which are critical to creating an inclusive and safe environment for LGBTQ members.

As part of our cultural competency training, we also encourage our providers to access information on the Office of Minority Health's "A Physician's Guide to Culturally Competent

Care." The American Medical Association, American Academy of Family Physicians, and the American College of Physicians endorse this program. Successful completion allows the provider to earn category one continuing medical education credits at no cost.

Monitoring Cultural Competency

We monitor the member experience using member complaint reports. Based on these results, if we identify an issue with culturally competent provider service delivery, our provider relations representatives contact the provider for additional cultural competency training. We also use CAHPS member satisfaction results that will show if a member feels their provider communicates well.

Provider Directory

ND010	The Vendor should describe how they will develop and maintain a directory of providers that includes provider names locations with street address, website URLs (as appropriate) and telephone numbers of current contracted providers in the member's service area.

Aetna has a current state-approved provider directory for the MHT and WVHB, and we will update as necessary for WVCHIP members. We meet all requirements as identified in Model Service Provider Agreement, Article III Statement of Work, Section 3.4.4 Provider Directory.

[ND010] Developing and Maintaining a Provider Directory

Aetna uses various provider demographic data to maintain our provider directory. We use provider lists provided by the Department, and we gather information from our own claims payment system for a remediation file and placement on our website. The steps we take to update the directory include **Online directory:** **We update our online directory daily from our electronic claims management system;** and **Print directory:** We pull information from our system and send the document to a printer for file creation and placement on the website.

Our provider data maintenance processes ensure that our publicly available directory always reflects the most recent and accurate information available including provider names, locations with street address, website URLs, and telephone number of our current contracted providers in the member's service area. Our provider directory also includes the non-English languages offered (including but not limited to American Sign Language) by the providers or their interpreters; whether the provider has completed cultural competence training; identification of providers that are not accepting new patients; any provider group affiliations; provider specialties; ADA accommodations (including offices, exam rooms, and equipment); and any restrictions on the member's ability to select from network providers.

Provider Directory Audits and Updates

We conduct monthly audits to confirm the accuracy of our provider listings, including review of Council for Affordable Quality Healthcare online provider information database. We audit the West Virginia provider directory to confirm the accuracy of provider listings and use this to make weekly updates to online directories, including changes in demographics and panel status. Aetna also assesses and collects information used in our provider directory such as physical accessibility and accommodations. These indicators are available across all provider types, including behavioral health, home health, and publicly supported and specialty care providers to help make sure the member selects the right provider. We update our online provider directory daily from our electronic claims management system. We also deliver an update of the provider directory on disk to the enrollment broker monthly, and we keep our current provider directory on our website. We provide affected members reasonable notice of any changes regarding providers, including any change in the names, locations, telephone numbers, non-English languages spoken by current contracted providers in the member's service area, and

identification of providers that are not accepting new patients. This notice will be provided at least 30 calendar days before the intended effective date of the change. We also notify beneficiaries annually of their right to request and obtain a provider directory and provide potential members a copy of the provider directory upon request within five business days.

Geographical Access Standards

ND011	The Vendor should its process to ensure its network adheres to geographic access standards for all adult and pediatric members.

Aetna ensures our network adheres to geographic access standards for all adult and pediatric members by generating geographical mapping reports for review by health plan and network leadership. Network staff will formulate a plan to close any identified gaps based on data or member feedback. The results of our monitoring efforts are reviewed by our Service Improvement Committee (SIC). The SIC develops and monitors action plans to ensure identified geographic access gaps are addressed. If barriers to appointment availability or accessibility are identified, our Network and Provider Relations teams work collaboratively with our providers to identify and implement meaningful solutions to address these issues. We use a variety of leading indicators to monitor access and accessibility that inform and supplement our core process for ensuring that our network meets the needs of our members. Please refer to **[ND001] and [ND002]** for further details about our network adherence and access standards.

Comprehensive Behavioral Health Provider Network

ND012	The Vendor should describe how they will establish provider contracts and include in its provider network all identified comprehensive behavioral health and Psychiatric Residential Treatment Facilities (PRTF), as defined within the Service Provider Agreement (SPA), for both pediatric and adult MHT members

Based on Department provider access to care requirements, Aetna will ensure access to the full range of specialty and facility services providers for members in applicable populations with behavioral health needs. **Our network currently meets 100 percent of the access**

requirements for psychologists and psychiatrists, and we have contracts with over 736 behavioral health specialists, including 29 inpatient and PRTFs in West Virginia. We also have contracts with 100 percent of SUD providers in the state.

We will focus on behavioral health issues and trauma caused by Adverse Childhood Experiences in children enrolled through TANF and CHIP eligibility. We are collaborating with **Cabin Creek Health Systems and the Marshall Health Center for Rural Health** in an evidence-based, integrated, intensive coordination of care approach that targets high-risk youth, including WVCHIP members, attending middle/high schools in Kanawha County to improve health outcomes. We are offering providers training on trauma-informed care in February 2020. This training will also include cultural sensitivity and health equity and was established in collaboration with the National Council for Behavioral Health.

Additionally, we collaborate with national and local behavioral health organizations, such as the Behavioral Health Provider Association, the National Association of Social Workers—West Virginia Chapter, and PROACT to continue to develop and support our behavioral health network in the state. Our established provider relationships and staff throughout our Aetna Medicaid organization are experienced in developing and maintaining similar networks in other states. We will leverage effective practices and modify them to fit the unique needs of West Virginia's providers and members.

Provider Hours of Operation, Member Convenience and Parity

ND013	The Vendor should describe how its network development and adequacy processes include and assess provider hour of operations, convenience to members, and parity to commercial or fee-for-Service (FFS) populations.

We use accessibility and availability standards based on requirements from National Committee for Quality Assurance (NCQA), state, and federal regulations. The access standards are

communicated to practitioners, providers, and members via the Aetna website and the member handbook and provider manual. Federal law requires that participating practitioners and providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. If the practitioner or provider serves only Medicaid recipients, hours offered to Medicaid managed care members must be comparable to those for Medicaid fee-for-service members. Providers that do not meet Aetna's access standards, including 24/7 PCP access, are provided recommendations for improvements. Our goal is to work collaboratively with the provider to make certain they fully understand and meet the requirements of access and accessibility.

Aetna also offers other methods that help members access services that are convenient to the areas where they live. Telehealth can be used as an alternative to or complement to traditional service delivery. It has also been proven to improve access to services in traditionally underserved remote or urban areas,

In addition, through our financial incentives program, we offer enhanced payment for those offering after-hours and weekend care. Standards for wait times and appointments, disability access, expertise, cultural sensitivity, and hours of operation are communicated through the provider manual, provider notices and alerts, during site visits, and in training documents.

Access to Care Guidelines and Monitoring

ND014	The Vendor should describe its guidelines and monitoring processes that ensure members have timely access to care per contractual requirements.

Aetna Network Development and Provider Relations staff monitor member access per contractual requirements. All participating providers in our network are contractually obligated by provider agreements to adhere to timely access and appointment standards, including specific

standards for PCP, specialty, urgent, and crisis services. We monitor our providers regularly to determine compliance with these requirements, including monitoring accessibility reports, member concern via calls, complaints, and grievances, and making onsite visits. If a contracted provider does not comply with these standards, we meet with the provider face-to-face and we will also take corrective action through our quality management program structure.

Selection, Credentialing, Retention, Maintenance

ND015	The Vendor should describe its process for the selection, credentialing, retention, and maintaining qualified providers.
ND017	The Vendor should describe how they will establish credentialing and re-credential that will comply with C.S.R Section 114-53.6.

Our experience serving MHT and WVHB members with our highly qualified and credentialed network enables us to offer services to WVCHIP members on day one.

[ND015] Process for Selection, credentialing, retention, and Maintaining Qualified Providers

Aetna has a proven process for selecting, credentialing, retaining, and maintaining qualified and quality providers in our West Virginia network. When we identify providers who wish to join our network, we send them a contracting packet that includes the following:

- Provider contract
- Appropriate credentialing forms
- Electronic fund transfer enrollment
- Provider portal enrollment form
- Instructions to sign up for electronic remittance advice
- Contact information for credentialing analyst

Provider Screening and Selection

Aetna requires that all network providers that order, refer, or render covered services are enrolled with the Department, through its fiscal agent, as a Medicaid provider, as required by 42 CFR 438.602(b). We understand that we are not required to contract with a provider that is enrolled with the Department if the provider does not meet our credentialing or other

requirements. When we identify a provider, who is interested in joining our network, but not currently enrolled with the West Virginia Medicaid program, we will work with the provider to submit an enrollment application with the Department's fiscal agent and verify the provider has been enrolled prior to contracting. Aetna requires providers who are seeking to join our network to submit their Internal Revenue Service Form W-9, provider information form, and application. The credentialing process includes but is not limited to verifying that the provider's required licenses and certifications are current and that the provider is eligible for participation through the National Practitioner Database. Aetna has processes in place to ensure compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under Medicaid, Medicare, or CHIP, as required by 42 CFR 438.610. We will collaborate with the Department's fiscal agent, including collaboration of conducting and responding to the results of monthly federal databases checks as required by 42 CFR 455.436 to ensure compliance of all entities per Article II, Section 8.6. As required, and to the extent that information is available, we will also coordinate with the State to verify the provider does not owe money to the Medicaid program and that the provider is not currently involved in an active Office of the Attorney General Fraud investigation. Aetna only contracts with the highest quality health care providers. We submit monthly reports to the Department with the names, National Provider Identifiers (NPIs), and Employer Identification Number or Medicaid identification number of any health care professional, institutional provider, or supplier that has been the subject of a program integrity action. Actions that will be reported may include denied credentialing, suspension, termination, CAPs, fines, or sanctions because of concerns about provider fraud, integrity, or quality deficiencies during the prior calendar quarter. The report will also identify action taken by Aetna. We will also report any health care-related criminal

convictions, when disclosed, to the Department and notify the appropriate licensing, disciplinary bodies, or other appropriate authorities.

Physician and other licensed health care professionals: Aetna's process for selecting physicians and other licensed health care professionals, including members of physician groups, includes our staff understanding of the following processes:

- Examine the PROV12 provider listing of newly enrolled providers to pre-select providers
- Review procedures for initial credentialing
- Evaluate procedures for re-credentialing at least every three years and recertifying and/or reappointing providers
- Review processes for receiving advice from contracting health care professionals with respect to criteria for credentialing and re-credentialing of individual health care professionals
- Assess written policies and procedures for denying, suspending, or terminating affiliation with a contracting health care professional, including an appeals process, and for reporting serious quality deficiencies to appropriate authorities

Institutional providers and suppliers: We have established processes that specify the intervals at which we determine and redetermine our providers and suppliers are appropriately licensed to operate in the state, are in compliance with other applicable state and federal requirements, and have been reviewed and approved by an appropriate accrediting body when applicable, or are reviewed and determined to meet the standards Aetna has established for such entity.

We do not discriminate against providers with respect to their participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable state law, solely based on such license or certification. Additionally, our selection and retention criteria do not discriminate against health care professionals who serve high-risk populations or who specialize in the treatment of costly conditions. If a provider is not accepted into our network, we provide written notice that includes

reasons the provider was not accepted, including information on their appeal process if applicable. If a provider is accepted, we send a written network participation welcome letter that includes a contract effective date for which providers are approved to begin providing medical services to members, as well as the required orientation information.

Credentialing Requirements and Procedures

Aetna will credential and re-credential new physical health and behavioral health providers in accordance with federal and state requirements, as defined by the Department. Our approach to working with providers is to be there to help at every step in the process, and to stay in constant communication so providers know the status of their application and if additional information is needed. **We employ a dedicated credentialing staff to assist providers and streamline the credentialing process for West Virginia providers.**

As an **NCQA 'Commendable' health plan**, Aetna has written credentialing and re-credentialing policies and procedures that comply with NCQA requirements, W. Va. C.S.R. §114-53-6 and 42 CFR 455, Subpart B, and other applicable federal and state laws, regulations, and requirements. We will continue to meet all requirements, including those included in the Model Service Provider Agreement Section 2.1. Aetna's National Quality Management and Measurement department is responsible for the following credentialing functions:

- Committee minutes, policies, and procedures
- Confidentiality and disclosure of credentialing
- Re-credentialing peer review information
- Assessment and credentialing of organizational providers
- Credentialing allied health practitioners
- Practitioner credentialing and re-credentialing
- Non-traditional providers credentialing and re-credentialing
- Credentialing office assessments
- Practitioner applications
- Reporting sanctions
- Practitioner participation and peer review, including a West Virginia practitioner

- Medical director credentialing
- Peer review credentialing and re-credentialing
- Coordination with Medicaid state plans for local approval

Aetna does not require providers to complete more than one credentialing or re-credentialing application. We complete credentialing and re-credentialing of providers within 90 days of receipt of all relative information from the provider. Aetna has a Physician Advisory Subcommittee that meets monthly to review the provider's application after the review by the Aetna National Quality Management and Measurement department process and provides approval of all of Aetna's credentialed providers.

We conduct credentialing or re-credentialing for all of our West Virginia providers prior to allowing them to be listed in the provider directory and serve members.

Individual providers: Individual providers who are members of a contracting group, such as an independent association or medical group, are credentialed individually. They must complete the credentialing application, which includes a work history covering at least five years. When Aetna conducts primary source verification, we gather proof of licensure, education, and training, evidence of graduation and specialty training, and valid Drug Enforcement Administration (DEA) or Department of Public Safety Controlled Substances Registration Certificate. The provider's office is contacted, if applicable, to complete the application and acquire additional needed documentation. Prior to admitting a provider into our network and every three years thereafter, we verify selected criteria with primary sources.

PCPs and specialists: The following are minimum data elements required for applications for PCPs and specialists:

- Professional license number
- Any physical or mental health problems that may affect current ability to provide health care

- Any history of chemical dependency/substance abuse
- History of loss of license
- Felony convictions as required by W. Va. C.S.R. §114-53-6.3 and other criminal convictions as required by 42 CFR 455.106
- History of loss or limitation of privileges or disciplinary activity
- History of debarment, suspension, or exclusion from any federal or state health care programs
- An attestation to correctness/completeness of the application

During the initial credentialing process, we verify the following:

- The identity and the exclusion status of provider and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of federal databases as described in 42 CFR 455.436
- The provider holds a current valid license to practice
- Valid DEA or Controlled Dangerous Substance certificate, as applicable
- Graduation from medical school and completion of a residency, or other post-graduate training, as applicable
- Board certification or eligibility, or specialized training as appropriate
- Work history
- Professional liability claims history
- Good standing of clinical privileges at the hospital designated by the provider as the primary admitting facility (this requirement may be waived for practices which do not have or do not need access to hospitals)
- The provider holds current, adequate malpractice insurance with minimum coverage requirements of $1 million per individual episode and $1 million in the aggregate
- Any revocation or suspension of a state license or DEA/Bureau of Narcotics and Dangerous Drugs number
- Any curtailment or suspension of medical staff privileges (other than for incomplete records)
- Any censure by the state or county medical association
- Any member complaints

Additionally, we request and review information on the provider from the National Practitioner Data Bank and appropriate state licensing boards, including but not limited to the Board of Medicine, Chiropractic Board, Osteopathic Board, and/or Dental Board.

Facility providers: Aetna follows current NCQA guidelines 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. They must have been reviewed and approved by an Aetna-approved

accrediting body, including but not limited to the Joint Commission and Community Health Accreditation Program, and participate in an onsite assessment if not accredited and a Centers for Medicare and Medicaid Services (CMS) or state survey is not obtainable. Minimum credentialing criteria includes verification of the following:

- 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 not on the Officer of Inspector General sanctions or Office of Staff Management sanctions
- Professional liability insurance
- Advance directive policy for hospitals and long-term care acute care hospitals
- Internal Revenue Service Form W-9 required during initial credentialing

SUD providers: We understand that the Department Administrative Services Organization contractor will complete the SUD provider certification process and provide a report to the Department. Final certification letters will be sent out by the Department, and Aetna will be notified of the certified providers by the Department. Contingent on the SUD providers receiving certification from the State, Aetna will credential all SUD providers consistent with the key benchmarks from American Society of Addiction Medicine® criteria as set forth in the Medicaid Provider Manual, Chapter 504. Aetna will meet the SUD provider network standards as outlined in Model Service Provider Agreement, Article III Statement of Work, Section 10.11.5 SUD Provider Certification, Credentialing, and Network and Appendix J.

Re-credentialing Process and Cycle

Individual and facility acute care providers are re-credentialed using Aetna's standard re-credentialing process every three years. We reverify and update all the stated information, including confirming that these providers are in good standing with applicable accreditation and regulatory agencies; have a signed contract or participation agreement; meet our standards and requirements; and are qualified to provide services to our members. We make sure providers

are appropriately licensed by the State and have an NPI number and appropriate ongoing certification and training, as required, and agreed to in their contract. We make certain all network providers are screened against state and federal exclusion registries, and we comply with all contract requirements. In addition to the information obtained during initial credentialing, the re-credentialing process also includes review of the following provided in **Table 6.7.1-3**.

Table 6.7.1-3: Information Reviewed for Re-credentialing Acute Care Providers

Information	Method for Capturing this Information	How the Information is Assessed
Member Complaints and Appeals	Member complaint and appeals data is collected by our Member Services department and the Appeals and Grievances department.	Member complaints are reviewed, and if any are related to quality and safety, they are investigated. Complaint monitoring reports are used to identify practitioner quality issues between re-credentialing cycles.
Utilization Management Information	Utilization management data is collected by our Medical Management department.	This data is reviewed and evaluated as part of the re-credentialing process.
Results from Quality Review and Provider Quality Profiling	Quality information collected through our quality management structure is obtained through routine data submission requirements and record reviews.	This data is reviewed and evaluated as part of the re-credentialing process.
Information from State Licensing Boards and Accreditation Agencies	Licensing and accreditation information is collected through review of state licensing boards and accrediting agencies.	This information is evaluated through the ongoing monitoring process conducted by the Credentials Verification Organization.

Additional Provider Specific Credentialing and Re-credentialing Criteria

In addition to the stated credentialing and re-credentialing requirements, Aetna has policies and procedures to support compliance with criteria applicable to certain provider types, as required in the Model Service Provider Agreement, Article III Statement of Work, Section 2.1.

Criteria for PCPs, OB/GYNs, and other specialists: Aetna conducts an onsite visit of PCPs, OB/GYNs, durable medical equipment (DME), behavioral health providers, and other high-risk providers or highly utilized specialists' offices and documents a structured review of the site and medical recordkeeping practices to ensure conformance with applicable standards. Site visits are conducted as a part of initial credentialing and may be conducted during the re-credentialing process that occurs every three years.

Credentialing and re-credentialing criteria for dental providers: Aetna has delegated credentialing and re-credentialing of the dental network to SKYGEN USA, our dental benefit administrator. As a part of our oversight of SKYGEN USA, we confirm that they have appropriate policies and procedures that comply with all credentialing and re-credentialing requirements as described. Additionally, we verify that SKYGEN USA's credentialing and re-credentialing criteria for dental providers includes verification of a current anesthesia permit and/or certificate from the West Virginia Board of Dental Examiners for those dental providers who induce central nervous system anesthesia.

Credentialing and re-credentialing criteria for behavioral health care providers and agencies: Aetna's processes for credentialing and re-credentialing behavioral health care providers and agencies includes the following criteria:

- Verification that comprehensive behavioral health centers and licensed behavioral health centers hold a current, valid license through the West Virginia Office of Health Facility Licensure and Certification
- Verification that independent psychologists and independent practicing licensed social workers hold a current, valid license with their professional boards
- Verification physicians are approved to provide Suboxone® treatment by the Department, and that physicians who intend to provide Suboxone treatment meet the following requirements:
  - Physician must qualify for a waiver under the Drug Addiction Treatment Act

- Physician must have an assigned DEA (X) number and complete the training regarding Suboxone treatment guidelines
- Physician must notify the Center for Substance Abuse Treatment of the intention to treat addiction patients

[ND017] Credentialing/Re-Credentialing that Complies with C.S.R. Section 114.53.6

Aetna has established and implemented state approved policies and procedures that address the selection and retention of our contracted provider network that are compliant with all applicable federal regulations, including but not limited to W. Va. C.S.R. §114-53-6.

Provider Contracting and Oversight

Aetna continues to contract with high-quality and diverse groups of providers in both large and small systems as we offer time-tested best practice strategies. As described previously, when we identify a non-contracted provider through a member request or feedback, we contact the provider to provide information regarding enrollment in the West Virginia Medicaid program and determine their willingness to join our network.

Provider contracting practices: Our policies and practices are developed to make sure Medicaid providers meet and maintain compliance with all applicable standards. We do not discriminate against providers who service high-risk populations, specialized conditions that require costly treatment, or based on the providers licensure or certification. Aetna's provider contracts comply with the terms of the contract, state and federal laws and requirements, and include any required standard contracts provisions. Our West Virginia Medicaid provider contract templates are available for review and approval upon request and will be provided as required in the Request for Proposal upon notification of award. Aetna understands the importance of the state mainstreaming of Medicaid beneficiaries into the broader health delivery system and includes contract terms expressly prohibiting contracted providers from intentionally

segregating Medicaid members in any way from other persons receiving services. The prohibited practices include, but are not limited to, the following:

- Denying or not providing a Medicaid member with any covered service or availability of a facility
- Providing a Medicaid member with any covered service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients, or the public at large
- Subjecting a Medicaid member to segregation or separate treatment in any manner related to the receipt of any covered service
- Assigning times or places for the provision of services based on the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, program membership, or physical or mental disability of the members to be served

Additionally, our contracts with PCPs prohibit such providers from closing their panels to Medicaid members without prior notification and consent by Aetna. If a PCP closes its panel, it must be closed to all individuals, and if reopened, must be required to admit patients on a first-come, first-served basis. If a PCP has the maximum of 2,000 Medicaid members, the PCP is permitted to admit additional, non-Medicaid patients. We require participating providers to sign an executed contract or letter of agreement between Aetna and themselves following negotiations. Once a contract is executed, we provide the Health Plan Reimbursement Administration (HPRA) department with a copy of the signed contract for review and operational analysis. HPRA submits a system change request form to the Configuration team to create a new contract in our claims system. The change request includes the signed executed contract or letter of agreement, the reimbursement schedule, codes, compensation schedules, and other requirements to pay services properly at correct rates as defined in the contract.

The new or modified contract will be configured in our claims system's applications development testing environment. This process streamlines the setup for new providers and increases quality and claims payment accuracy. The Medicaid Provider Services (MPS) team will run through a

series of claims to validate accurate configuration of the contract. Once MPS passes the contract, an Internal Quality Control team will also review. The contract is then promoted into the production environment ready for provider assignment/linkage. A provider change request is submitted to the Provider Data Services department to create or modify a new provider record. The provider is aligned to the designated contract on the provider change request, including additional provider information (i.e., language, provider type, specialties). We validate the provider load and complete the process.

Oversight and monitoring provider compliance

In addition to our formal credentialing, re-credentialing, and contracting processes, we have established a variety of mechanisms to assess provider contract compliance and identify potential noncompliance. These include conducting routine site visits and surveys; monitoring member and provider complaints and grievance and appeals, both at a case and trend level; reviewing data and reports submitted to our Special Investigations Unit, Compliance department, and compliance hotline; reviewing quality management data and reports; and reviewing notifications received from the Department. If a potential concern is identified, our Provider Relations staff coordinates with the appropriate Aetna departments to assess or investigate the matter and determine whether the provider is compliant with the applicable contract requirements. The assessment or investigation may occur in a variety of ways, based on the circumstances, including but not limited to conducting a record or documentation review, an ad hoc onsite survey, and interviews with the provider.

Retention Strategies

Our model of provider engagement is designed in support of the philosophy that developing long-term relationships built on mutual trust improves provider retention. Aetna continually looks

for innovative strategies to engage, satisfy, incentivize, and retain providers. We use performance improvement projects, educational initiatives, community forums, and regionally based projects to help providers improve their practices, create better health outcomes for members, and reduce administrative costs and burdens.

We use **high-touch, face-to-face, and personalized engagement** activities including one-on-one meetings with our Provider Relations staff to help them understand their managed care contract, Aetna's policies, and procedures, how to file claims, and receive electronic payments. Each Aetna West Virginia provider will have an assigned provider relations representative who is familiar with their local providers and will meet face-to-face regularly and as requested to provide training, build trust, foster open communication, and develop collaborative relationships. This approach enables each office to become familiar with its representative and form a solid working relationship. Provider relations representatives engage with providers through a variety of mechanisms designed to provide proactive, prompt, and collaborative communications.

Additionally, we work to **minimize provider administrative burden** and provide ease to access support through the following activities:

- A designated provider relations representative who is familiar with the provider
- No requirement to submit paper or electronic referrals for services
- A dedicated provider call center
- Utilization management process simplification; for example, we put a limit on the benefit in lieu of a prior authorization requirement for trigger point injections. A provider in the eastern West Virginia panhandle indicated this was a significant burden when a new patient required this service because the member would have to return for another appointment rather than receiving the injection the same day of the first appointment. We allowed six trigger point injections in a 12-month period.
- Technical assistance and training related to claims submissions and the technical interfaces providers have with Aetna. As a result, in 2019, 94 percent of claims are submitted by electronic data interchange (EDI) and more than 88 percent are auto-adjudicated. In addition, over the last 12 months in 2019, our average turnaround time for EDI claims is 8

days, our average turnaround time for paper claims is 13 days, and our 2019 payment and procedural financial accuracy rate was 99 percent.

- Self-service and online tools through the provider portal and interactive voice response that make it easier for providers to interface with Aetna

We use simplified contracting using streamlined agreements that are fully compliant with state and federal requirements. The ability to sign an electronic agreement using Adobe e-signature makes it convenient for a provider to return and sign their document within hours.

As part of our recruitment and retention strategy, Aetna offers providers a variety of **alternative payment arrangements** through our Aetna Better Value program. Our programs are customizable, allowing us to combine the most applicable components for a provider into a comprehensive and effective, innovative alternative payment model (APM). Through Aetna's value-based payment arrangements, we can incentivize cost, utilization, and quality improvement through a reduction in potentially preventable events (primary, specialty, and hospital-based) such as hospital readmissions, avoidable ER visits, avoidable inpatient visits, and preventable complications. Using quality and performance measures in the contracts with APMs helps us to determine the provider's success, and together we make continuous progress toward West Virginia's goals for member access to quality care.

Annually, Aetna issues four levels of Quality All Star awards—Gold, Silver, Bronze, and Partnership—to providers for increases and improvements in their Healthcare Effectiveness Data and Information Set (HEDIS) scores. The Quality team works in conjunction with Provider Relations to engage our providers to continually increase their quality of care.

Aetna's physician incentive plan approach includes primary care and specialty care (including behavioral health and hospital-based care) and expands into other treatment venues, such as community mental health centers, FQHCs, RHCs, and non-traditional providers. Aetna has an

established APM program in West Virginia affecting 21 percent of our membership. Our current APM options include pay-for-quality, shared risk, shared savings, and capitation. **Aetna has paid over $22,495,000 in value-based payments over the past two years, including a risk payout.**

Maintaining Qualified Providers

Aetna values and collaborates with our providers by forging strong relationships with them to maintain a robust provider network. Some of our **Provider Relations team members live in the regions where they work** and demonstrate extensive knowledge of the providers' and members' needs at the local level. Providers receive personalized attention and agile responsiveness from their assigned Provider Relations staff who meets with them in their offices and facilities for improved communication. We offer simplified and timely credentialing, contracting, and amendment **processes that ease the administrative burden for providers.** Through ongoing provider engagement and education, we keep providers informed and offer the necessary support to ensure **they can stay focused on our shared number one priority, delivering the highest quality of care to our members.** Additionally, as **we obtain feedback from providers via site visits, provider forums, Joint Operating Committee meetings, and other stakeholder meetings and committees where we receive valuable commentary that drives development of new provider incentives and tools to strengthen provider satisfaction and maintenance of the network.**

Provider Enrollment with Department

ND016	The Vendor should describe how they will ensure that its network providers have completed enrollment with the Department as required by CMS Medicaid and CHIP Medicaid Managed Care Final Rule.

Our experienced staff have worked with West Virginia Medicaid providers for more than 23 years, enabling us to make sure our credentialing and contracting processes, including provider

enrollment, are efficient and effective. Aetna verifies network providers have completed enrollment with the Department required by CMS Medicaid and CHIP Medicaid Managed Care Final Rule during our credentialing recredentialing processes. Practitioners or providers who provide services to our members must be enrolled as a Medicaid and/or WVCHIP practitioner or provider at each practice location with the State of West Virginia and credentialed by Aetna before they can provide health care to our members. To assist providers and support network development, Aetna has established a process to guide and support providers through the Medicaid and WVCHIP enrollment process. Through this process, providers can send Aetna their Medicaid and WVCHIP enrollment application in a variety of ways, including email or mailing a hard copy. Once we receive the application, we review to verify that all required fields have completed and that the information is legible. If we identify any deficiencies, we reach out to the provider to obtain the information or corrections needed to complete the application.

Site Visits

ND018	The Vendor should describe how they will establish site visit criteria and evaluation as part of its credentialing process for PCPs, OB/GYNS, DME providers, behavioral health providers, other high-risk providers, and other highly utilized specialists.

Aetna will expand on our current site visit criteria for PCPs and OB/GYNs to include DME providers, behavioral health and other high-risk and/or highly utilized providers, and specialists. Aetna has established site visit criteria and evaluation as part of our credentialing process. We use the site visit criteria using Department requirements and NCQA credentialing standards, such as access and hours of operation, ADA compliance, and medical record keeping practices. We document this structured review of the site and medical recordkeeping practices to ensure conformance with applicable standards. We conduct site visits as a part of initial credentialing and may be conducted during the re-credentialing process that occurs every three years.

Reimbursement of Services during Mid-transfer of Treatment

ND019	The Vendor should describe its process for reimbursement of services that occur during mid-transfer of a treatment, when a recoupment is not available through the original provider (for example, orthodontia)

Although an infrequent occurrence, we have an established process for reimbursement of services that occur during mid-transfer or treatment. Aetna allows a member to continue an ongoing course of treatment with the provider/practitioner for up to 90 calendar days from the date of our member Notification Provider Termination letter. Aetna's definition of 'ongoing course' is defined as a member receiving treatment from a practitioner during the previous six months for a condition that requires follow-up care or additional treatment, or the services have been prior authorized, such as in the case of a member who is pregnant and in her second or third trimester. Maternity services can continue with the provider/practitioner who is being terminated through the completion of the member's postpartum care. Member choice, including the ability to select a PCP, is our principal goal, especially when transitioning care. When a provider is terminated, members receive information and assistance to make a PCP change. Aetna's Member Services staff and Care Management team are available to assist members in selecting a new PCP.

Aetna complies with the Model Service Provider Agreement, Article III Statement of Work, Section 9.6 and 9.7 Orthodontic Services. We reimburse for children's orthodontic services and cover the entire duration of treatment. We confirm, in conjunction with the Department and SKYGEN USA, continuity of care for active orthodontia cases from January 1, 2014, until care is completed and providers are fully reimbursed. We will pay for orthodontic services not previously reimbursed under the fee-for-service as a part of the global payment fee. We allow a member to continue receiving orthodontic services with an existing out-of-network provider and

maintain written orthodontic continuity of care records. We make an initial payment which covers the entire treatment plan, and if the member disenrolls midway through the course of treatment, we do not retract any portion of the payment regardless of the member's tenure with the plan.

Notifications

ND020	The Vendor should describe how they will establish notification processes related to provider network terminations including but not limited to, the following:
ND021	Notification to the Department and the enrollment broker with advanced written notice of any Primary Care Provider (PCP) network deletions within fourteen calendar days
ND022	Written notification to members, at least thirty calendar days prior to the termination, to allow the opportunity to select a new Primary Care Provider (PCP) before being assigned one
ND023	Immediate notification of a hospital termination to the Department

Aetna currently has established processes related to network terminations and in compliance with Model Service Provider Agreement, Article III Statement of Work, Section 2.1.8. Network Changes.

[ND020] Establishing Notification Processes

Aetna makes every effort to ensure that our relationships are strong enough with our providers to resolve issues as they arise. We take every step to resolve deficiencies, complaints, grievances, and any other concerns to ensure that our members have a solid and comprehensive network to avoid disruptions in care, and to ensure provider continuity and consistency. Consistency in providers, however, must also be balanced with member safety and quality care. As such, it is our practice to terminate provider contracts for cause when we identify safety or significant quality concerns, or noncompliance with credentialing requirements. It is not our practice to terminate provider contracts arbitrarily for no cause.

Except in the case of death or illness, the provider agrees to notify us at least 90 days in advance of disenrollment and agrees to continue care for his or her panel members for up to 30

days after such notification until another PCP is chosen or assigned. We recommend the provider have an established policy for dismissing patients from the practice. Aetna members should be seen and treated in the same manner as other patients the provider sees. Services or appointments cannot be refused in emergency or urgent care situations unless the provider has given a member with at least 30 days' notice and requested that they select another practitioner. In the event of a member dismissal from the practice, the member should be notified in writing. We strongly encourage the provider send us a copy of the dismissal notification letter sent to the member. If requested, we can assist the member in selecting a new provider.

[ND021] Notification to the Department and the Enrollment Broker

In accordance with our current processes, we notify the Department and the enrollment broker of any changes to our network that materially affects our ability to deliver services within 14 calendar days of such change identified. In the event of an Aetna-prompted PCP network termination, we will notify the Department and enrollment broker with advanced written notice within 14 calendar days. Our process for notifying the Department of provider contract terminations meets the requirements of Model Service Provider Agreement, Article III Statement of Work, Section 2.1.8 Network Changes, and will contain the following:

- The reason and a brief description of the provider's actions and/or applicable information leading to termination
- The provider's NPI, Medicaid identification number, entity name, and provider type (two-digit)
- The provider's complete mailing address
- Assurances of how we will maintain network adequacy and access to care despite the provider termination
- Aetna's plan to make sure members are transitioned in a manner that ensures continuity of care

The written notice to the provider includes the reason for Aetna's decision; the effective date of termination; the provider's right to appeal the decision; and how to request an appeal. The focus

of our processes, monitoring, reporting, and communication is to make certain covered and medically imperative services are available to members. As required, we will obtain prior approval of the survey tool from the Department and will provide survey results upon request.

[ND022] Written Notification to Members

Aetna's processes and policies surrounding network provider termination make certain we notify members in a timely manner and the member has continued access to covered services. In compliance with Model Service Provider Agreement, Section 2.2.6 PCP Transfers, in cases of PCP withdrawals, Aetna provides members with at least a 30-calendar day notice whenever possible to enable them the opportunity to select a new PCP before being assigned one. Our Provider Relations team coordinates with Member Services staff to start the process of member notifications and maintain continual care for members impacted by the termination of a provider.

We understand that members with a disabling condition, chronic illness, or who are Supplemental Security Income-eligible, have a choice of specialist physician to serve as their PCP. If the member's PCP is a specialist, we will send the member information about how we will assist the member to transition care to another specialist.

Aetna Care Coordination staff will assist a member selecting a new PCP. Our member transition process includes the following:

- Identifying affected members through data and reports from Care Management and Utilization Management and claims data
- Identifying priority members, such as those in currently in an inpatient setting, scheduled to have surgery, in the middle of care, or with complex medical needs, to ensure individual care plans are developed or updated as appropriate
- Providing members with notice and assigning care managers to do targeted outreach to members and make sure we understand continuity of care needs
- Reviewing geographical mapping reports to determine geographic impact and implement targeted strategies to identify and contract with other providers, including the use of SCAs and telehealth, as necessary, to maintain compliance with network adequacy standards

- Initiating clear communication protocol between the Care Management and Provider Relations department regarding identified network needs through targeted member outreach and individual care plans and making certain network development activities occur in real time to respond to identified member needs.

For terminations involving specialists, members who have received a service from the terminating provider twice within the previous 6 months are notified in writing within 15 days from the date we send the termination notice to the specialist, or from the date we receive notice from the specialist of non-participation in the network. We will also send the member information about selecting a new specialist and how we will assist the member during transition.

[ND023] Immediate Notification of a Hospital Termination to the Department.
Aetna will report any disenrollment of hospitals from our network to the Department immediately in compliance with the Model Service Provider Agreement, Section 2.1.8. Network Changes.

For example, when St. Mary's Medical Center notified us of their intent to terminate their contract in 2013, we notified the Department via email on the next business day. We also sent out notification letters to providers with privileges at St. Mary's Medical Center, members who lived in Cabell County (where the facility was located), and members who had been seen at the facility in the last 12 months. These letters were sent within 14 days of the termination notice from the hospital with information about the change in their participation status and alternative facilities that were in network where members could be seen.

8. Provider Services

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Provider Services (PS) as part of their bid. The Vendor's narrative response should not exceed 50 pages.

Our provider services approach drives provider engagement, education, and collaboration that supports the Department for Health and Human Resources (Department)'s vision to improve communication and training among stakeholders. We work with West Virginia providers and the Department to reduce fragmentation and streamline administrative tasks to allow easier flows of information that help coordinate care for our members, especially for those with chronic conditions.

Our provider services solutions include dedicated locally based West Virginia Provider Relations teams, enabling our proactive provider engagement. In addition, we enrich the provider experience by providing significant training, self-service tools, and information technology (IT) supports to improve data sharing with providers, as well as innovative provider incentives aimed to enhance quality of care and strong local relationships to improve access and health outcomes.

Provider Services Operating Model

PS001	The Vendor should provide a description of its Provider Services operating model.

Through our more than 23 years of working in West Virginia, we have developed a deep understanding of West Virginia providers. Aetna's comprehensive provider services functions include services and tasks to ensure providers receive education and support to effectively service the Mountain Health Trust (MHT), West Virginia Health Bridge (WVHB), and West Virginia Children's Health Insurance Program (WVCHIP) members.

Our provider services operating model leverages knowledge of West Virginia and our experienced Provider Relations and Provider Call Center staff, relevant training opportunities, and self-service tools to enable providers to streamline processes for member care, as described throughout this response. Our provider services solutions support providers and requirements contained in the Model Service Provider Agreement, Article III Statement of Work, Section 2.6.1 and as shown in **Table 6.8.1-1**.

Table 6.8.1-1: Aetna Provider Services

Model Service Provider Agreement Requirements	Aetna Provider Services Solutions
Assisting providers with questions concerning enrollee eligibility status	• Provider relations representatives • Provider portal search 24/7 • Provider call center staff • Interactive voice response 24/7
Assisting providers with plan prior authorization and referral procedures	• Provider relations representatives • Provider manual • Provider call center staff • Provider training • Website • Provider portal • Prior authorization code specific look-up tool
Assisting providers with claims payment procedures	• Provider relations representatives • Claims Inquiry and Research staff • Provider manual • Provider training • Website
Handling provider complaints	• Provider relations representatives • Provider manual • Provider portal – link to policies • Provider call center staff
Providing and encouraging training to providers to promote sensitivity to the special needs of this population	• Initial provider orientation • Provider forums • Provider relations representatives • Cultural competency training • Trauma-informed care training

Model Service Provider Agreement Requirements	Aetna Provider Services Solutions
Educating providers about MHT, WVHB, and WVCHIP	• Provider relations representatives • Provider call center staff • Provider orientation toolkit • Initial and ongoing provider training • Provider forums
Educating providers on our written policies on the False Claims Act, including policies and procedures for detecting and preventing waste, fraud, and abuse; this requirement is pursuant to the deficit Reduction Act of 2005, section 6032	• Provider relations representatives • Initial and ongoing training • Provider manual via provider portal
Offering targeted supports to key providers, such as navigating managed care systems and coordination with physical and behavioral health providers	• Provider relations representatives • Premier Provider Relations representative • Care Management staff • Care Coordination team
Expanding our innovative contracting strategies through targeted incentives and compensation models more lucrative for providers who adopt evidence-based practices and time-tested clinical approaches to care management	• Value-based payment model • Network development director

We also incorporate effective practices from our shared service partners, such as provider specific issues relating to claims, encounters, and coding. This approach aids our ongoing identification and implementation of provider experience approaches to support and respond to our providers.

Experienced Provider Relations Staff

Aetna's highly trained and experienced Provider Relations staff have over 100 combined years of West Virginia Medicaid experience. Our staff is located in diverse communities across the state to ensure strong and collaborative provider relationships. These individuals support and train providers to easily navigate administrative processes and facilitate care for MHT, WVHB, and WVCHIP members, including those in rural regions, and provide support and refresher training as needed.

Under the direction of the chief executive officer (CEO), our provider relations director oversees our provider services operating model and is responsible for developing and issuing guidance, training, and technical assistance on emerging and urgent issues to support providers and make sure member needs are promptly met.

We also offer Premier Provider Relations services to the largest four providers in West Virginia to provide a more personalized and in-person communication approach for **West Virginia University, Marshall Health, Cabell Huntington Health, and Charleston Area Medical Center (CAMC) Health System**. We have created a rapport with each facility and an open working relationship in which to resolve issues and develop pilot programs to better serve our West Virginia members. This relationship has resulted in less provider abrasion and has also allowed the other provider relations representatives to offer equal focus to the smaller facilities and practitioners in our state.

Provider Relations Staff Training

The key to Aetna's Provider Relations staff success begins before we hire, as we select employees with appropriate experience, training, education, and direct provider relationships that demonstrate effective provider relationship management.

Provider Relations staff training provides new staff with foundational information including the following:

- Aetna's organization and internal operations
- An overview of West Virginia's MHT, WVHB, and WCHIP program requirements
- An overview of the Department and Bureau of Medical Services
- Covered services, including Aetna value-added services
- Centers for Medicare & Medicaid Services requirements
- Cultural competency and health literacy
- Trauma-informed care
- Strategies to support providers in meeting member needs
- Quality of care

- Value-based payment provider program
- Americans with Disabilities Act
- Fraud, waste, and abuse (FWA)
- Compliance
- Code of Conduct
- Privacy
- Lean Six Sigma
- Systems navigation
- National Committee for Quality Assurance (NCQA)
- Contractual, state, and federal requirements specific to individual job functions

Our Provider Relations team also receives ongoing training on policy and programs changes that occur. They receive training on community health events, trauma-informed care, cultural competency, and detailed compliance training. They also receive ad hoc training on topics that may include demographic changes and updated Healthcare Effectiveness Data and Information Set (HEDIS) and non-HEDIS results.

Locally Based and Regionally Assigned Provider Relations Strengthens the Provider Experience

Each Aetna West Virginia provider will have an assigned provider relations representative who will engage with them regularly and as requested to provide training, build trust, foster open communication, and develop collaborative relationships. This approach enables each provider office to become familiar with its representative and form a solid working relationship.

Provider relations representatives engage with providers through a variety of mechanisms, including in-person meetings and training, electronic communications, and phone communication designed to provide proactive, prompt, and collaborative communications.

Our provider relations representatives are champions of the delivery of West Virginia-specific training and education for providers, in alignment with Aetna's overall mission, core values, and strategic plan and in compliance with all relevant federal, state, and local regulations. Provider relations representatives serve as the primary point of contact between Aetna and our network

providers and provide education and assistance regarding a variety of topics. Provider relations representatives visit or phone provider offices periodically to ensure their experiences with us are seamless. They meet routinely with office staff, practitioners, or providers and are available to meet upon request. **Our West Virginia Provider Relations staff conducted 586 site visits in 2019.**

Our Provider Relations staff also send news, electronic messages, and specialized mailings to providers periodically that include updates to the manual, changes in policies or benefits, and general news or information of interest to our provider community. We send provider notices at least monthly, and more often as needed.

Provider Relations staff responsibilities include the following:

- Provide education to practitioner and provider offices
- Provide support on Medicaid and WVCHIP policies and procedures
- Clarify contract provisions
- Assist with demographic changes, terminations, and initiation of credentialing
- Coordinates the ongoing HEDIS and non-HEDIS education of network providers and provision of gap in care reports
- Monitor compliance with applicable state and federal agencies
- Conduct an annual Provider Satisfaction Survey
- Analyze and create action plan in alignment with NCQA requirements
- Conduct member-complaint investigation
- Maintain the provider directory
- Assist practices to obtain secure web portal or member care login information
- Serve as a point of contact for any provider concern

As depicted in **Figure 6.8.1-1**, our provider relations representatives are locally based and regionally assigned to serve providers in all regions of the state.

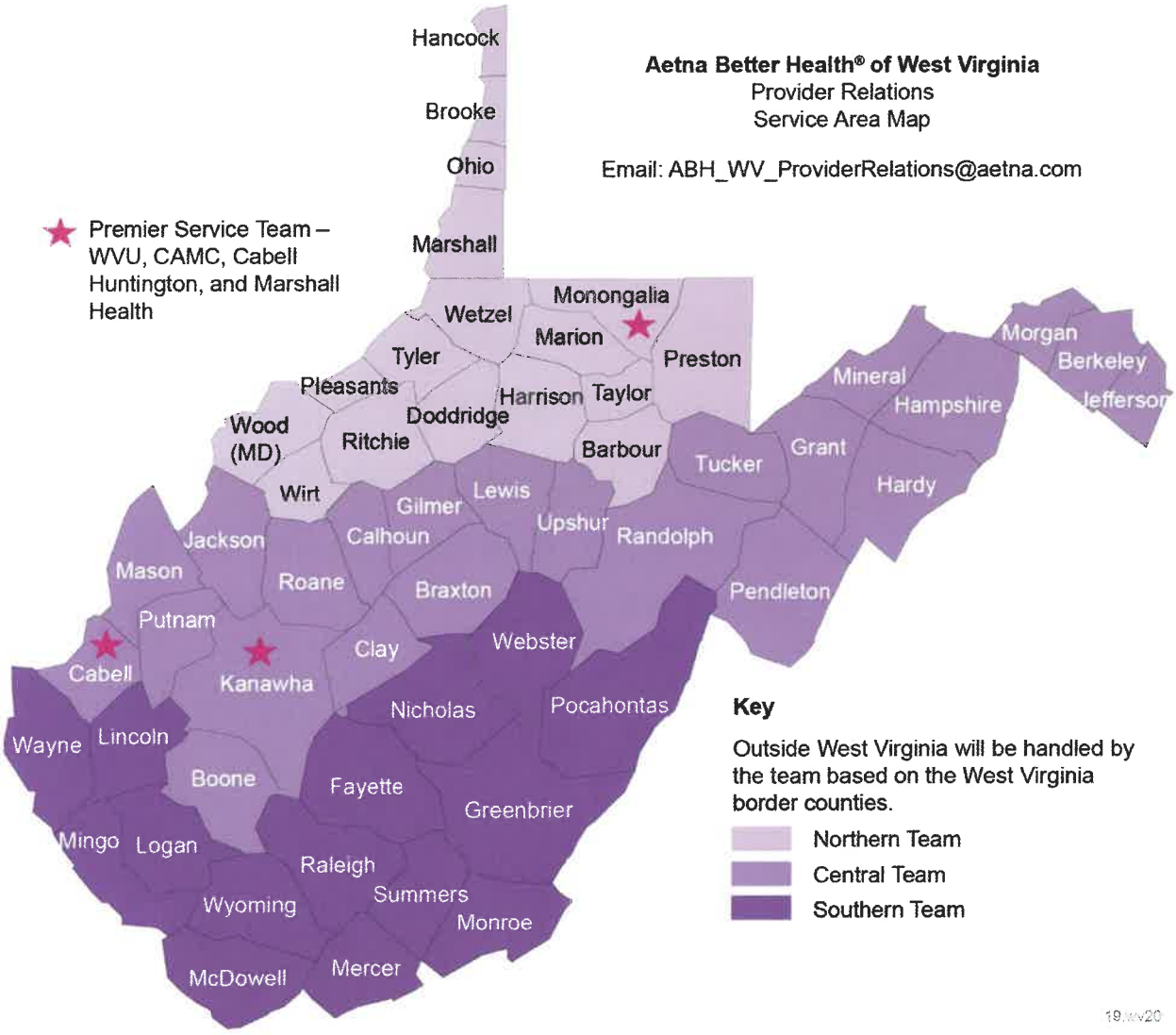


Figure 6.8.1-1: Provider Relations Service Area Map
Our high-touch provider relations representatives serve providers throughout the State.

Regionally Assigned Teams

As another part of our operating model, we employ teams to serve each region. These teams are comprised of a provider relations representative who meets with providers in their offices to provide education and support, a designated network relations specialist who works on directory updates, claims project research, and provider notices, and a credentialing analyst who works with onboarding new providers and assists with credentialing criteria.

Premier Provider Relations

Our Premier Provider Relations service was created to provide enhanced service to some of our largest network hospitals and physician groups, including **West Virginia University, Marshall Health, Cabell Huntington Health, and CAMC**. This dedicated regional provider relations representative conducts a regularly scheduled onsite visit, attends Joint Operating Committee meetings (CAMC), and conducts a bi-monthly or monthly conference call to review claims issues that have been identified. They also conduct monthly conference call touchpoints and visit CAMC bi-weekly. **Figure 6.8.1-2** shows a recent site visit at Roane General Hospital, a member of CAMC's clinically integrated network. The providers welcome this personalized approach and are comfortable in knowing that we are working to resolve their issues as quickly as possible. Since the program began in April of 2018, we have worked with these facilities to build professional relationships that ensure that these providers know that Aetna Better Health of West Virginia is willing to go the extra mile to ensure premier services are provided.



Figure 6.8.1-2: Site Visit at Roane General Hospital
Provider Relations and Quality staff meet with Roane General Hospital.

Our Provider Relations staff also participate in regularly scheduled provider association meetings, including the Rural Health Care Provider Association, West Virginia Chapter of the American Association of Pediatrics, Primary Care Association, West Virginia State Medical Association, Behavioral Health Provider Association, and the Medical Office Managers Association. We have found participation

in these established meetings allows us to reduce provider burden by decreasing their external meetings, while still offering needed information and education.

High Performing Provider Call Center

Aetna's Provider Call Center operations currently exceed and will continue to comply with all state requirements, including those outlined in the Model Service Provider Agreement, Article III, Statement of Work, Sections 2.6.1. Aetna's call performance results exceed these requirements as shown in **Table 6.8.1-2** below. Our Provider Call Center is managed and operated by highly trained staff members who receive training on the West Virginia medical, behavioral health, publicly supported, and specialty providers. Our experienced staff are fully equipped to respond to a variety of provider inquiries about topics including claims/invoice status and information, member eligibility, general program information, and how to provide guidance and education specific to individual provider types, including significant traditional and non-traditional providers.

2019 Post-call Survey Results

- Provider satisfaction: 96.7%
- First-call resolution: 96.3%

Our Provider Call Center live-answer hours of availability are from 8:30 a.m. to 5:00 p.m., Monday through Friday. After regular business hours, the line is answered by an automated system that advises callers of the operating hours and provides instructions on alternative methods to verify member enrollment. For example, while there is no requirement for providers to seek enrollment verification prior to providing emergency services, providers can check eligibility 24/7/365 through the Aetna secure website (https://www.aetnabetterhealth.com/westvirginia/login). Our interactive voice response (IVR) capabilities also enable providers to access claims information, auto-fax explanation of benefits/remits, check prior authorization status, check member enrollment, and access

frequently asked questions 24/7/365. Aetna has also established a direct line for contracted providers to call for a peer-to-peer discussion related to authorization denials.

Table 6.8.1-2: Provider Call Center Performance

Contract Performance Standards	2019 Aetna Performance Results
83% of calls are answered live within 30 seconds during operating hours.	83% of calls are answered live within **17 seconds** during operating hours.
The call abandonment rate does not exceed 5% of total calls for the reporting period.	The call abandonment rate is **.06%** of total calls for the reporting period.

We also offer the opportunity for providers to rate our service by completing a brief quality survey after the call has been completed.

Provider Initial Orientation, Training and Support

PS002	The Vendor should describe how its Provider Services Department will provide initial provider orientation, annual training, and support to its provider network.
PS005	The Vendor should describe its annual review process of its provider manual, including thirty business days prior notice of any material changes to impacted providers.

Aetna has a long-term relationship with the providers in West Virginia and we continue to engage, educate, communicate, and support our providers to enhance service delivery to MHT, WVHB, and now WVCHIP members. Aetna understands the importance of providing effective education and training programs that are accessible to providers. We have more than 23 years of experience in West Virginia provider training initiatives and have existing curricula that we can customize for WVCHIP processes. We will provide training sessions and host provider forums for ongoing training regarding the program and the services Aetna offers. Training sessions and updates on pertinent topics will be made available to the network providers annually and as needed. Our provider orientation and education meet or exceeds requirements detailed in the Model Service Provider Agreement, Article III Statement of Work, Section 2.6.1.1.

[PS002] Provider Orientation, Annual Training and Support

In addition to formal trainings, Aetna offers self-service tools and multiple interactive training platforms to enhance communication with the provider offices. This allows providers to select a modality (webinars, instructor-led, self-paced, onsite) that best fits their practice and assure all providers receive the same level of training.

Initial Orientation

Our approach to provider orientation and education is geared toward offering our providers the information they need in the most convenient and effective method available. Aetna's MHT, WVHB, and WVCHIP provider training program will build upon our current training program and will be designed to aid providers in meeting the needs of these populations, while minimizing provider burden.

Under our current West Virginia Medicaid contract, Aetna has established formal initial engagement and orientation practices, which will be continued for newly contracted providers, including WVCHIP providers. This initial engagement also includes sending our Provider Orientation Toolkit (please refer to **Figure 6.8.1-3**), initial provider training, and one-on-one support and education provided by our locally based Provider Relations staff.

Our Provider Orientation Toolkit is designed to convey important information quickly and in a functional, easy-to-follow format. It includes information about how to participate in our provider training orientations and information and instructions on how to access our provider manual and portal, as well as key contact information. The Provider Orientation Toolkit also includes a welcome letter, orientation schedule, and identification and contact information for their assigned provider relations representative. Our provider relations representatives email or mail

the Provider Orientation Toolkit to newly contracted providers. The Provider Orientation Toolkit is also accessible on our website.

We understand that providers are our most valuable service delivery assets. Our job is to empower them by providing education, assistance, and the resources needed to achieve quality member engagement.

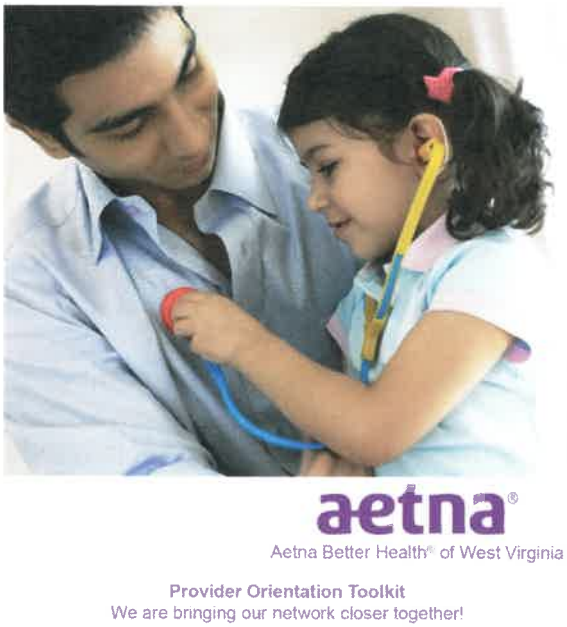


Figure 6.8.1-3:
Provider Orientation Toolkit
Our Provider Orientation Toolkit conveys important information quickly and in a functional, easy-to-follow format.

Our regionally assigned Provider Relations staff directly contact new providers either in person or by phone, based on the provider choice, to begin establishing a relationship, to review key information, and to respond to any provider questions or concerns. As a part of the implementation process, we will offer our current providers orientation training on MHT, WVHB, and WVCHIP, as well as training on requirements for providing health care services and behavioral health care services to West Virginia members.

We conduct new provider orientation within 30 days of the provider joining the network. Materials are sent directly to the provider and reviewed during either an onsite or webinar-based meeting. As part of orientation, we supply providers with an orientation toolkit and providers are given information on a variety of topics including the following:

- Provider relations representatives' contact information
- An overview of the website

- Provider portal overview/enrollment
- Review of access and availability standards
- Cultural sensitivity standards review
- Provider enrollment requirements
- Taxonomy/National Provider Identifier education
- Claims submission guidelines, including the claims resubmission/reconsideration process and remittance advice retrieval
- Information on the provider complaint process and appeals/grievance process
- Fraud, waste, and abuse reporting process
- HEDIS overview
- Population health programs and specific information to address the provider's needs

In addition to our orientation program, Aetna continues to engage our providers through the

following means:

- **Site visits (face-to-face):** Our provider relations representatives visit the individual primary care provider and specialist offices to offer ad hoc trainings on topics such as basic billing and address provider issues, and provider re-orientations via internal or external request. For example, providers indicated they wanted additional training on prior authorizations, and we include this topic in our ongoing and ad hoc training activities.
- **Pre-recorded training:** To improve provider access to the orientation information and training, Aetna is in the process of making pre-recorded trainings available to providers, so they and their staff can complete the training at times that are most convenient for them.
- **Provider Forums:** We conduct annual provider forums in six locations throughout the state. In 2019, forums were conducted in Martinsburg, Clarksburg, Wheeling, Charleston, Huntington, and Beckley. Topics included fraud, waste, and abuse, care management, utilization management, provider/member incentives, claim resubmission/dispute/appeal, and community outreach. **Aetna's regional provider forums have gained a reputation for being responsive and helpful to West Virginia providers, as evidenced by the 65 percent increase in participation from 2018 to 2019.**
- **Provider scorecards:** We will use provider scorecards to allow appropriate trending and provide proactive feedback to address areas of opportunity. These scorecards will be available for providers in 2021.
- **Training webinars:** We have a provider education plan that includes a new topic each quarter. Supplemental trainings are routinely offered and hosted via webinars. Recent topics include the West Virginia Foster Care rollout, HEDIS coding for 2020, and changes to West Virginia Medicaid Program (2nd quarter 2019).
- **HEDIS toolkits:** Includes tips on how to appropriately close gaps in care inclusive of proper coding and HEDIS guideline interpretation.
- **Email blasts:** We notify providers of policy and program changes through email blasts that are sent as frequently as needed.
- **Trauma-informed care toolkits:** These toolkits will be available for providers on our website in 2021. They will contain information on evidence best practices, addressing adverse childhood experiences, and types of trauma in primary care setting.

- **Feedback from our call center:** We use both member and provider call center data to track, trend, and identify opportunities for additional provider education topics.
- **E-consult and telephonic consultation services to primary care providers (PCPs):** The primary care setting has become the gateway to behavioral health services, such as mental health and substance use. PCPs need support and resources to screen and treat persons with low acuity conditions. E-consult provides PCPs access to United States-licensed, board-certified specialists from major academic centers across the country via an electronic health record-linked portal, which increases overall capacity.

Annual and Ongoing Training

In addition to new provider orientation, we conduct annual and ongoing training to address the needs of different provider audiences. Our annual and ongoing education efforts also address best practices to serve MHT, WVHB, and WCHIP members. As we continue our partnership with the Department and collaborate with our providers, we look to sharing new service approaches and promising evidence-based practices gathered from providers and our experiences. We welcome the opportunity to collaborate with West Virginia Children's Health Insurance Agency and WVCHIP providers to update and enhance our training topics and approaches.

Aetna's provider relations director develops and maintains the West Virginia Provider Training and Education Plan. The provider relations director participates in meetings to improve communication and support inclusion of stakeholder feedback and collaboration related to the provider training program. For example, our Provider Orientation Toolkit and monthly orientation webinars were developed based on provider feedback, which requested more information about working with the plan.

We will also develop or enhance trainings based on provider feedback and/or Aetna-identified trending provider issues or process pain points identified in feedback from providers. For example, we will be offering providers training on trauma-informed care on February 12 – 13,

2020. This training opportunity will also include training on cultural sensitivity and health equity and was established in relationship with the National Council for Behavioral Health.

All providers will be offered ongoing training through a variety of mechanisms, including but not limited to, quarterly provider webinars, provider forums, and one-on-one meetings. A description of new and ongoing training topics is also contained in **Table 6.8.1-3.**

Table 6.8.1-3: Initial, Annual, and Ongoing Provider Training

Training Topic	Provider Audience	Training Description/Topics Included
Provider Training		
New Provider Orientation	New providers (existing providers receive updated orientation information through the training updates listed in this table)	Aetna's new provider orientation training covers a broad range of topics, designed to make sure new providers understand program requirements and how to access resources. Topics include the following: • Overview of Aetna and contact information • Provider relations service area map • Accessing the provider portal instructions • Signing up for electronic funds transfer and electronic remittance advice • West Virginia MHT, WVHB, and WVCHIP overview • Provider Relations and Member Services functions and contact information • Provider website, secure provider portal, and provider manual • Covered services including physical health and behavioral health services, and dental and vision care • Medication coverage and prior authorization • Medical prior authorization, authorization timelines, and medical necessity guidelines • Claims processing including clearinghouse, clean claims, and claim submission • System of care • FWA • Provider communications • Member rights and responsibilities • Access and availability standards • Cultural sensitivity standards • Non-discrimination and reasonable accommodations for members with disabilities

Training Topic	Provider Audience	Training Description/Topics Included
		• Medical record standards • Dispute resubmission and appeals education • HEDIS
Annual and Ongoing Provider Training		
Training Updates	New and existing providers	Training update topics will vary dependent on identified needs, but will generally address refresher information related to topics covered during initial provider trainings, including ongoing required training on topics, such as the following: • Policy updates • FWA • Care management • Utilization management • Provider/member incentives • Claims resubmission • Dispute and appeals • Community outreach • The application of American Society of Addiction Medicine (ASAM) criteria in the assessment and level of care processes
Cultural Competency	New and existing providers	All our contracted providers, including behavioral health providers, receive cultural competency training at orientation and on an ongoing basis via our website, including the following: • Cultural competency and impacts on health care • Provider obligations for delivering culturally competent care • Tools and resources such as Aunt Bertha, an online repository of community services • Social determinants of health and trauma-informed care • Training staff on the need to understand and respect cultural differences and develop services that better meet the needs of minority populations and remove barriers to care • Assisting members with limited English proficiency • Providing access to interpretive and American Sign Language services for Aetna members • Assessing feedback from members about programs, quality initiatives, member materials, and other education and outreach tools to meet their cultural and linguistic needs

Training Topic	Provider Audience	Training Description/Topics Included
LGBTQ Cultural Competency	New and existing providers	This training will be designed to make sure providers are trained and demonstrate skills to serve the lesbian, gay, bisexual, transgender, and queer self-identifying (LGBTQ) population; to provide appropriate screening of members for behavioral health needs since they are at a higher risk; to provide education on addressing discrimination at both an individual and system level; and that providers understand language is essential, such as using correct identifying pronouns, and that forms and resources account for diverse perceptions of sexuality, sex, and gender; and to understand that strict confidentiality practices are critical to creating an inclusive and safe environment for LGBTQ members.
Trauma-informed Care Training		
Trauma-informed care	New and existing providers	**Level 1: Foundational Awareness**. Individual practitioners are well-informed about ubiquity of trauma and its likely impact on their patients/clients. They understand the critical role of social determinants of health (SDOH) as drivers of clinical, functional, and quality of life outcomes. Provider organizations are committed to becoming trauma informed.
		Level 2: Enhancing Routine Clinical Practice. Individual practitioners have integrated Level 1 knowledge into routine clinical practice using evidence-based tools. Provider organizations promote trauma-informed primary prevention as a routine practice for all members, analogous to childhood vaccinations, flu shots, and provide member education and assessment and SDOH as standard elements of a person's treatment/recovery plan.
		Level 3: Basic Trauma-informed Care: Individual practitioners expand routine clinical practice by integrating treatments, services, and supports that explicitly address trauma. Provider organizations perform trauma-informed secondary prevention for all people they serve, using universal screening for early adversity, historical, and ongoing trauma, and for SDOH risk factors.
		Level 4: Advanced Trauma-informed Care: Individual practitioners include considerations of complex trauma and SDOH within routine clinical practice, using a

Training Topic	Provider Audience	Training Description/Topics Included
		biopsychosocial model of care that integrates physical and behavioral health. Provider organizations include a trauma-informed center of excellence for at least one high-risk/rising-risk population, marginalized population, or for people with complex needs.
		Level 5: Close/Full Collaboration in a Merged Practice: Provider organizations include trauma-informed (Level 3-4) individual practitioners on interdisciplinary care teams, in addition to the usual treatment team members for that provider organization. There are high levels of collaboration and integration between behavioral and physical health providers, consistent with Substance Abuse and Mental Health Services Administration's Integrated Care Level 5 or 6.
		Level 6: Trauma-informed System of Care: Provider organizations collaborate across sectors to meet the complex needs of people they serve within a larger community context. They implement a broad, community-wide focus on the underlying social and economic conditions in which people live, in addition to supporting people to meet their immediate individual needs and bridging the dichotomy between individual-level social needs and community-level social determinants. While targeted, small-scale social interventions provide invaluable assistance for individuals, the provider organization remains focused on the social determinants that perpetuate poor health at the community level

Substance Use Disorder Provider Training and Education Requirements

Aetna will comply with Model Service Provider Agreement, Article III Statement of Work, Section 10.11.6 SUD Provider Training and Education Requirements. We understand that substance use disorder (SUD) providers are responsible for providing training and education to their staff on the ASAM Level of Care criteria and the application of the ASAM criteria in the assessment process. As part of the Department's quality-monitoring strategy, personnel and clinical records of a sample of the provider network will be reviewed to evaluate if there is appropriate application of and fidelity to the ASAM Levels of Care and the Medicaid provider manual. Aetna

will perform onsite review of providers' application of and fidelity to the model during credentialing and will perform onsite reviews of providers to ensure SUD program providers are consistently applying ASAM criteria throughout an individual's stay and that documentation and personnel records meet established Medicaid standards. Our behavioral health manager will also assist with ASAM criteria training for providers as needed.

Provider Support

Aetna offers a multifaceted approach to provider support. On the front lines, our Provider Relations staff offer education and help as needed. Our Aetna West Virginia provider manual offers a guideline and access to a wealth of information to support providers. Our communications tools and training enable providers enhanced knowledge of the program and continued education to best serve members' needs. We also offer self-service tools, such as our provider portal and IVR that offer providers information and tools at their fingertips.

> A rural West Virginia crisis stabilization provider began having financial difficulties, in part due to billing errors, which led to a temporary closure. Aetna's Provider Relations staff spent a day at the provider's office retraining their staff—and continued to provide technical assistance for several weeks to support the provider's resubmission of corrected claims. As a result, the provider was able to reopen the needed facility and continue serving the community and our members.

Provider Relations Representatives

Aetna's Provider Relations staff members are the cornerstone of our provider outreach and engagement activities. We have actively recruited Provider Relations staff that have familiarity with the Department. Our staff are in communities across the state to ensure strong and collaborative provider relationships.

Provider Manual

Our provider manual gives our network providers access to a broad range of information and guidance on Aetna's administrative processes and meets all requirements within the Model

Service Provider Agreement, Article III Statement of Work, Section 2.6.2. Aetna has, and will maintain, a West Virginia provider manual for MHT and WVHB members. We will include information for providers specific to serving the Children's Health Insurance Program population upon implementation.

We include information on how to access the provider manuals on our website and in our Provider Orientation Toolkit, to make sure providers have access within five days of inclusion in our network. We also deliver a hard copy of the provider manual to providers, upon request.

Aetna will continue to submit our provider manual annually, including any provided by a subcontractor for direct services, and any updates to the Department for approval. We document the approval of the provider manual by the Aetna administrator and medical director and maintain documentation confirming that the provider manual is reviewed at least annually. When there are Department policy or program changes or Aetna procedure or service site changes, we will send notification to the affected providers at least 30 calendar days before the intended effective date of the change.

Aetna maintains a provider manual policy to ensure production of a quality product meeting the Department' requirements. At a minimum, the Aetna Better Health of West Virginia provider manual includes the following information:

- Description of the program
- Covered services
- Emergency service responsibilities
- Policies and procedures that cover the practitioners/provider complaint system:
  - Aetna information includes, but is not limited to, specific instructions regarding how to contact Aetna's provider relations representative or manager to file a practitioner/provider complaint and which individual(s) has/have the authority to review a practitioners/provider complaint
  - The required procedural steps in the member grievance process, including information about the grievance system such as the address, telephone number, and office hours of

the grievance staff. Also included is information on the member's right to request continuation of benefits while utilizing the grievance system; timeframes and requirements; the availability of assistance in filing; the toll-free numbers within the caller's geographic area; and reasonable access to the health plan without undue delays. The health plan also provides specific phone numbers to call to present a complaint, grievance, or appeal.

- Medical necessity standards and practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions
- PCP responsibilities
- Other practitioner/provider or subcontractor responsibilities
- Prior authorization and referral procedures, including required forms
- Medical records standards
- Claims submission protocols and standards, including instructions and all information required for a clean and/or complete claim
- Protocols for submitting encounter data
- Notice that practitioner/provider complaints regarding claims payment should be submitted to Aetna
- A summary of Aetna's cultural competency program and how to obtain a complete copy at no cost
- Information on Aetna's quality improvement programs
- Member rights and responsibilities in accordance with 42 CFR 438.100
- Information notifying providers that the health plan is authorized to implement any mandatory process necessary to verify that the practitioner/provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s) as a participating practitioner/provider of the health plan and that the practitioner/provider's submission of encounter data is accepted by the Department and/or the State's encounter data warehouse.

Aetna is responsible for verifying that all practitioner/provider, service, and product standards specified in the Department provider manual and the health plan's own provider manuals are incorporated into Aetna's standard participation agreements by reference.

PS005 Provider Manual Annual Review Process

Aetna will continue to submit our provider manuals, including any provided by a subcontractor for direct services and any updates to the Department for approval, within 30 business days' prior notice of any material changes to impacted providers. The CEO, in collaboration with the provider relations director, is responsible for the accurate, timely, and sufficient development and distribution of Aetna's provider manual. Additionally, these managers have the responsibility to establish and oversee the processes that will monitor practitioner/provider knowledge and

understanding of practitioner/provider requirements and assist in the development of any necessary corrective actions to confirm compliance with such requirements.

Our Network and Provider Relations teams participate in an annual review of the manual to ensure we include additional information about new population groups, any new Department or federal regulations, or Aetna operations updates. The Network and Provider Relations teams distribute the provider manual to directors/managers in all health plan areas to make updates to operations and or regulations, such as review of the following:

- Member Services: Contact numbers, member rights, and any updates
- Claims: Claims submission protocols and any updates
- Information Systems: Website, portal, and other systems procedures/updates
- Care Management: Medical necessity standards, practice guidelines, prior authorization guidelines and any revisions
- Quality Management: Quality program descriptions and any revisions
- Disputes and Appeals: Procedures for disputes and appeals processes and any updates
- Fraud, Waste, and Abuse: FWA procedures and any revisions
- Compliance: Aetna compliance guidelines, legal compliance, and Department compliance

We also include provider recommendations, such as clarifications of requirements. Recently a provider requested clarification on claims submission, and we revised the information in the manual to clarify claims submission requirements. Once we gather the Aetna departmental review and feedback, revisions are made to the manual and then Aetna sends it to the Department for approval.

Provider Notices and Alerts

We regularly publish provider notices and alerts, the main source of mass communication to participating practitioners and providers. Recent provider notice topics include the 2019 Consumer Assessment of Healthcare Provider and Systems (CAHPS) Member Satisfaction Results and 2019 Medical Record Documentation Results. This information is located on the website at https://www.aetnabetterhealth.com/westvirginia/providers/provider-news. These

notices and alerts may include provider manual amendments, which also become a part of the provider's contract. The notices explain amendments and keep participating providers abreast of issues including, but not limited to the following:

- Program changes
- Policy and procedure changes/updates
- Network changes
- Changes in the schedule of allowances
- Billing information
- General topics of interest

We also communicate regularly with our West Virginia participating providers by sending broadcast emails and faxes. We broadcast a text banner on our website to indicate any important changes as well. When there are program or service site changes, we provide the notification of changes at least 30 days before the intended effective date of the change.

Supporting Providers by Offering Self-Service Tools

Aetna supports our providers by offering self-service tools that providers can access at their convenience 24/7. Aetna offers a secure web-based provider portal, an IVR system, and our Aetna Better Health of West Virginia website. These tools especially benefit smaller practices or those located in rural areas that may not be able to travel or leave their offices to complete training. Rural providers receive information about these self-service tools during new onsite provider orientation, in webinars, or in the new provider orientation packet. We also promote them at workshops and our provider forums, and we create accounts for them onsite at the forums/workshops if they so choose. For example, one of our provider relations representatives recently helped **Essential Needs Home Care** in Whitehall set up their web portal account onsite and they also conducted web portal training with the office staff.

Web Based Provider Portal

Aetna's secure web-based provider portal offers providers access through secure single sign-on functionality that improves efficiencies for providers and offers complete accessibility to provider and member data and reports.

Our web-based platform allows us to communicate member health care information directly with providers in real time, including the following:

- Member eligibility, member identification (ID) cards, and panel rosters
- Status of a member's compliance with HEDIS measures
- Prior authorization lookup tool designed to perform ID-specific searches for authorizations by member, provider, authorization data, and submission/service dates
- Review prior authorization requirement by specific procedures or service groups and show details on codes and any noted prior authorization exception information
- Review current status of all prior authorizations
- Export Current Procedural Terminology/Healthcare Common Procedure Coding System code results and information to Excel
- Obtain information on specific providers' claims status and remittance advice by provider user account ID and submit appeals and disputes.
- Access provider training materials and the provider manual
- Inquiry capability to communicate directly and securely to Aetna Medicaid organization provider support staff

We are aware of the new requirements regarding electronic authorizations, under HB2351, and will comply with these changes. We continually review and identify opportunities to improve the functionality and ease of use of our provider portal and respond to changing program needs. As such, we have begun to pilot a provider-centric, web-based portal to significantly improve the provider experience with a more robust set of self-service tools and information to help decrease provider administrative burden and increase efficiency. This capability, delivered by Availity, is an MCO payor agnostic tool which deeply resonates with providers as it allows them to manage much of their payor administration functions without relying on separate and proprietary MCO specific applications.

Other planned improvements include simpler submission of attachments to support administrative and clinical process, such as appeals; ease in contacting Aetna directly through the portal; and improved access to provider demographic updates.

During new provider orientation, we review the provider website and functionality and assist providers in registering for the portal. Providers may also request ongoing or refresher guidance, as well as assistance with logging into the portal either by contacting their Provider Relations staff or our Provider Call Center. Providers can also register for the portal through our website.

We monitor the use of our portal and provide the 2019 results of portal use in **Table 6.8.1-4**.

Table 6.8.1-4: Provider Portal Use

Functionality Name	Number of Hits Since 1/1/19	Percentage Functionality Search
Authorization Search	82,191	13.68%
Claim Search	261,217	43.48%
Member Search	225,154	37.47%
Panel Roster Search	738	0.12%
Provider Search	2,767	0.46%
Remittance Search	28,752	4.79%

Our **prior authorization tool** is within the provider portal. Aetna's prior authorization code specific look-up tool within our provider portal enables providers to perform ID-specific searches for authorizations by code, or code set.

Interactive Voice Response Self Service
In order to support provider self-service capabilities, especially during off-business hours, Aetna has deployed an easy to use and efficient IVR system. Aetna offers providers 24/7 access to information and services including:

- Claim status inquiries
- Member eligibility
- Member benefit coverage
- Claims submission instructions
- Prior authorization submission information

Almost 10 percent of provider calls to the Aetna support service staff are successfully closed through IVR self-service menus, and another 87 percent are warm transferred live to those teams with enriched information which helps expedite providers' needs. The Provider IVR prompts are as follows:

- Press number one for claims
- Press number two for eligibility and benefits information
- Press number three for transportation
- Press number four for authorizations
- Press number five for interpretation services
- Press number six for more options

Aetna Better Health of West Virginia Website

Our publicly available website provides a wealth of information for our provider network and offers the following:

- Announcements and news, including policy updates and state notifications
- Electronic solutions, including electronic fund transfer and electronic remittance
- How to join the network, including applications and credentialing criteria
- Provider manual
- Provider portal
- Resources such as Health Insurance Portability and Accountability Act 5010/ICD10, claims information, and special programs
- Education resources for cultural competency and health literacy
- Practice guidelines
- Document library

We are committed to making sure our providers receive the best possible and latest information technology, and tools available. We continually strive to eliminate redundancy and streamline process for our providers.

Provider Information Systems Support

Aetna complies with Model Service Provider Agreement, Article III Statement of Work, Section 2.6.4 Provider Information Systems Support. These accommodations are not in violation any requirements promulgated pursuant to Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (August 21, 1996), as amended or modified, Health Information Technology for Economic and Clinical Health Act, and other applicable federal and state laws.

We continue to develop **and utilize meaningful and complete electronic health records (EHRs) for each member and other IT supports to improve data sharing.** Our digital platform has evolved to include a Personal Health Record (PHR) electronic application through which Aetna Medicaid organization members, providers, and authorized care group participants can maintain and manage health information in a private, secure, and confidential environment. We will deploy the PHR application in support of the new contract. Sharing integrated EHRs, West Virginia health information exchange (HIE), SDOH, and care plan and claim data with the users supports the expansion of interoperability, providing additional care management and care coordination for our members.

As part of our West Virginia HIE, EHR, and personal health record plan, we will continue to engage in a full statewide stakeholder assessment and listening tour to understand the opportunities to expand data obtainment and sharing. Successful negotiations with West Virginia Health Information Network and CMT-enabled Aetna Medicaid organization access to much of their data have been integrated into our systems as described above. Additionally, as our digital platforms continue to evolve, we will look to use these systems as integration points for HIE data, including services like push notifications to member and provider digital devices,

alerts and secure messaging for our web-based portals and mobile applications, and greater EHR interoperability to provide critical, actionable data where providers need it most.

Specialists Serving as PCPs

PS003	The Vendor should describe its process for specialists serving as Primary Care Providers (PCPs), and related monitoring activities.

Aetna establishes and implements guidelines regarding which specialists will be able to serve as a PCP for applicable populations as identified in Model Service Provider Agreement, Article III Statement of Work, Section 2.2.3. Our PCP Assignment policy 4500.03 incorporates the state requirements. Members with a disabling condition or chronic illness or who are Supplemental Security income (SSI)-eligible have a choice of specialist physician to serve as their PCP. The specialist physician must agree to perform all PCP duties required in the service provider agreement and the PCP duties must be within the scope of the specialist's license.

A nurse midwife in the eastern region has requested to serve as a PCP for one of their members.

The steps required for a member to request a specialist PCP is as follows:

- If a member, or their parent or legal guardian, contact the Member Services department regarding such a request, we will advise the member that Aetna will contact the provider and request that the provider submit confirmation of their agreement to serve as a PCP and to be responsible for assuming responsibility for all PCP-specific requirements. Our Member Services staff will also recommend that the member directly contact the specialty provider to aid in expediting the request.
- Aetna will send the identified specialist a notice informing the specialist of the member request that the specialist serves as their PCP, including information regarding applicable PCP requirements, such as the following:
  - Information regarding PCP requirements, including but not limited to, responsibility for coordination of care
  - Requirements related to Early and Periodic Screening, Diagnostic and Treatment services
  - Identification of any PCP provider training the specialist may be required to complete
- The PCP will be asked to affirm their capacity to timely render all PCP services.
- Upon receipt of written confirmation that the specialist agrees to serve as the PCP for the identified member, including all required PCP activities, the request will be reviewed by the medical director or their physician designee. Reviews will be conducted on a case-by-case

basis and will include verifying that required PCP services are within the scope of the specialist provider license.

- If a request for specialist to serve as a PCP is denied by Aetna, the member will be notified of the decision, the reason for the denial, and applicable grievance and appeals rights and how to file a grievance or appeal with our Member Services department.

When a specialist provider is approved to serve as a PCP, Aetna will monitor the specialist's provision of PCP services, as indicated in Model Service Provider Agreement, Article III, Statement of Work, Section 2.2.1 PCP Responsibilities, through monitoring of data through the West Virginia Health Information Network, claims data, and medical record reviews. Our Provider Relations staff also monitor specialists serving as PCPs to ensure that they are fulfilling PCP roles and responsibilities, including a survey to attest panel size and accessibility survey. We will conduct site visits and assign a Care Coordination staff member to review gaps in care and make sure they meet standards for site practicing, accessibility standards, and ability to perform PCP services within the scope of practice. If an issue is identified, our Provider Relations staff follow up within 60 days to make sure the issues have been resolved. We continue to monitor compliance and if issues are not remediated, reeducate on the criteria and develop a correction plan as needed.

Cultural Competency Training

PS004	The Vendor should describe how its Provider Services Department will provide training to its provider network regarding culturally competent care.

A culturally competent provider effectively communicates with members and understands their individual concerns. It is incumbent on providers to make sure members understand their care regimen. Each segment of our population requires special sensitivities and strategies to embrace cultural differences. Good communication between members and providers contributes **directly to member satisfaction and positive outcomes.**

Aetna training requirements reflect the commitment of person-centered care that is responsive to the unique needs found in West Virginia. Cultural competency and health literacy are key to our service delivery. Annually, Aetna's health care equity director creates a detailed Cultural Competency Plan (CCP) to ensure engagement and alignment with Culturally and Linguistically Appropriate Services (CLAS) standards. The CCP includes the processes to develop and maintain a culturally competent staff and provider network and includes strategies designed to assist our providers integrating cultural and linguistic competence and health literacy into every aspect of member care. Our CCP emphasizes effective care by respecting and honoring each member's cultural health beliefs, practices, preferred language, special needs, and socioeconomic background. Aetna utilizes the U.S. Department of Health and Human Services (DHHS) Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care and follows DHHS' A Blueprint for Advancing and Sustaining CLAS Policy and Practice to inform the annual revision of our policies.

We continuously assess member demographics to best understand language and interpreter needs and develop innovative provider collaborations to serve members within their home communities. Our providers should verify that members are effectively receiving understandable, respectful, and timely care compatible with their cultural health beliefs, practices, and preferred languages and honoring member's beliefs.

Providers receive orientation and ongoing cultural competency training via face-to-face instruction, forums, or webinars about such important topics as the following:

- The reluctance of certain cultures to discuss mental health issues
- The impact that a member's religious and/or cultural beliefs can have on health outcomes
- The problem of health illiteracy and the need to provide members with understandable health information (e.g., simple diagrams, communicating in the vernacular)

- The progression of civil rights for people with disabilities
- Physical and programmatic barriers that impact people with disabilities
- Provider obligations for delivering culturally competent care
- Resources and tools such as Unite Us and Aunt Bertha, an online repositories of community services
- SDOH and trauma-informed care
- The need to understand and respect cultural differences and to develop services that better meet the needs of minority populations to remove barriers to care
- How to assist members with limited English proficiency
- Access to interpretive and American Sign Language services for Aetna members
- Review feedback from members about programs, quality initiatives, member materials, and other education and outreach tools to meet their cultural and linguistic needs

We realize that it is critical to provide quality service that addresses diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the member prevalent language(s) and sign language interpreters.

Our continuous monitoring of member demographics enables us to understand the individuals we serve. For example, 2018 data shows that in Beckley and Bluefield, nearly 25 percent of our members are African American. Our regionally based Care Connections team and System of Care and Provider Relations staff work collaboratively with West Virginia providers to ensure these members receive care that addresses their cultural beliefs. Important considerations for member care include lack of trust in the health care providers and the system—the idea that "we trust individuals most like us"; fear that surgery may cause cancer to spread; and apprehension in using opioids for pain management for fear of addiction. Older adults may seek treatment from home remedies, prayer, spiritual healers, and advice from family and friends; a lack of spiritual imbalance may be seen as any physical, mental, acute, or chronic disease.

Additionally, West Virginia ranks highest in nation for children who are transgender aged 13 to 17 years. We will meet the needs of LGBTQ members by providing clinical staff and provider

training to understand the cultural values and practices within the community and to address discrimination at both an individual and system level. We will train providers to understand that appropriate language is essential, such as using correct identifying pronouns, and to understand that strict confidentiality practices are critical to creating an inclusive and safe environment for LGBTQ members.

In addition and as a part of our cultural competency training, we encourage West Virginia providers to access information on the Office of Minority Health's "*A Physician's Guide to Culturally Competent Care*." The American Medical Association (AMA), American Academy of Family Physicians, and the American College of Physicians endorse this program. This program provides up to nine hours of category one AMA credits at no cost.

Holding Members Harmless and Protected from Balanced Billing

PS006	The Vendor should describe how members are held harmless and protected from balance billing for covered services.

One of the most significant member complaints we receive is when a provider bills them for a balance of payment other than co-pays. Our highly trained member services representatives receive member complaints and 99 percent are resolved on the first call. Our Member Services staff monitor and trend member complaint data and reach out to Provider Relations to educate providers on balance billing and/or other member compliant issues.

We prohibit Aetna participating providers, by contract, from billing members for any balance of payment for covered services, or as otherwise permitted under applicable law. Our contracted providers should accept reimbursement from Aetna in full. Members are educated of this process through the member handbook and by speaking with any of our Member Services or Care Management team members.

If a member reports that a provider is balance billing for a covered service, our member services representatives contact the provider to research the complaint and provide education about the requirements. If the provider does not resolve the issue, our provider relations representative will contact the provider. If our provider relations representative determines that the member was confused with balanced billing upon additional research, the provider may then seek reimbursement from a member when a service is not a covered benefit and the member has given informed written consent before treatment that they agree to be held responsible for all charges associated with the service.

If, after Provider Relations intervention and education, the provider continues to balance bill members, Aetna will develop a corrective action plan or terminate the provider. Aetna will notify the Department when a provider continues the inappropriate practice of balance billing a member.

Value-Based Payment

PS007	The Vendor should describe how they will develop comprehensive Value-Based Payment (VBP) strategies that link provider payment levels to quality of care outcomes.

Aetna offers providers a variety of alternative payment (APM) arrangements through our Aetna Better Value program. Our programs are customizable, allowing us to combine the most applicable components for a provider into a comprehensive, effective, and innovative APM. Many high-quality providers find value-based arrangements an attractive means through which to join a network. **Aetna has paid over $22,495,000 in value-based payments over the past two years, including a risk payout.**

[PS007] Comprehensive Value-Based Payment Strategies

Through Aetna's value-based payment arrangements, we can incentivize cost, utilization, and quality improvement through a reduction in potentially preventable events (primary, specialty, and hospital based) such as hospital readmissions, avoidable emergency room (ER) visits, avoidable inpatient visits, and preventable complications. Using quality and performance measures in the contracts with APMs helps us to determine the provider's success, and together we make continuous progress toward West Virginia's goals for member access to quality care. Aetna's physician incentive plan approach includes primary care and specialty care (including behavioral health and hospital-based care) and expands into other treatment venues, such as community mental health centers, federally qualified health centers, rural health clinics, and non-traditional providers.

Provider Relations staff educate providers about our established APM program in West Virginia. Our current APM options affecting 21 percent of our membership include pay-for-quality, shared risk, shared savings, and capitation. Among the tools we use to achieve appropriate delivery of care and manage utilization of services, Aetna Better Value offers providers an array of Health Care Payment Learning and Action Network alternative payment models (HCP-LAN APM) designed to facilitate participation of providers—large and small, traditional and non-traditional. From physician incentive plans with patient-centered medical homes (PCMHs)/advanced medical homes to shared risk and then to full-risk capitation, we work toward having most of our network providers successfully moving across the value-based continuum within the HCP-LAN framework. We work individually with each practice on the framework and guidelines and customize them based on the provider's interest and readiness.

Provider Relations and Network Development collaborate with the Aetna national team to determine the type of contract to offer each provider—pay for performance, per member per month, shared savings, or capitation based on the number of members being served and current quality scores for the group. Provider Relations and Network Development coordinate a meeting with the provider group to present and discuss the proposal. Our national team participates as needed to provide detailed information about the types of reporting available.

We place emphasis on advancing providers through the APM continuum. For example, we review a monthly reconciliation of member rosters, care gap reports, HEDIS scores, chart review, and incentives. Annually, Aetna issues four levels of Quality All Star awards to providers for increases and improvements in their HEDIS scores. The Provider Relations and Quality teams work collaboratively to acknowledge and reward providers who excel in HEDIS performance and provide quality care to our members, as depicted in **Figure 6.8.1-4**. To engage our providers to continually increase their quality of care, the Provider Relations team provides education and resolves barriers and our Quality team provides HEDIS education, helps providers to close member gaps in care, and provides guidance to help improve documentation and coding.



Figure 6.8.1-4:
Aetna Awards Cabin Creek Health System
Aetna Provider Relations and Quality staff met with Cabin Creek Health System to celebrate their Quality All-Star Award and present them with a commemorative trophy on November 13, 2019.

As providers evolve along the APM value continuum, we link incentives to improved quality, reduced costs, and increased member satisfaction and engagement. For example, we have

added a shared savings agreement with **Marshall Health** and **Charleston Area Medical Center** clinically integrated network. For the first time ever, we are working with **West Virginia University** on a value-based payment agreement for 2020. **We have identified 1,603 key providers and have a significant membership—17,304 members driving higher quality health outcomes— helping to meet the state goal to enhance quality of care.**

Our unique approach with these providers improves the health of West Virginians through innovative, whole-person care, and well-coordinated systems of care addressing medical and non-medical drivers of health. Aetna plans to use the APM arrangements described in **Table 6.8.1-5**. These models were selected based on the current and future predicted capabilities of providers in West Virginia. Our goal is not to move providers too quickly; rather, we want to work with them, give them support, and help them gain confidence to move to the next level of model for success.

Table 6.8.1-5: Types of Arrangements Aetna Plans to Use in West Virginia

Type of Arrangement	Rationale for Selecting Model	HCP-LAN APM Framework Maturity Level
PCMH arrangements	Allows practices to get infrastructure funding to support transformation (such as health information technology and care delivery support) within their practices. NCQA certification is not required.	2A
PCMH with quality incentives	Allows rewarding for performance on specific quality measure targets and infrastructure payments to support transformation, as well as adoption of trauma-informed care.	2C
Shared savings arrangements	This all-upside arrangement allows practices to become familiar with the connection between cost and quality performance and allows for sharing of cost savings after quality targets are met.	3A
Bundled payments	This is an up- and downside arrangement related to bundled payments for services and allows	3B

Type of Arrangement	Rationale for Selecting Model	HCP-LAN APM Framework Maturity Level
	specialists to participate in value-based programming.	
Primary care PCMH with shared savings and losses (losses will be capped initially)	This up- and downside arrangement allows PCPs with more capabilities to share in the savings to a greater extent while they are at risk for some losses—after meeting quality targets.	3B
Partial population payments for primary care	This arrangement begins to introduce population-based capitated payments for PCPs for a specific population of members they are treating. This arrangement will be for selected providers who are willing to be partially paid for those specific primary care services.	4A

We recognize the importance of creating a glide path for the provider and health plan to advance to APM models that are more sophisticated. This is accomplished by doing the following:

- Systematically assessing provider readiness for APM models
- Providing on-the-ground provider support for practice transformation
- Providing tools and data to support provider success
- Moving providers along the APM continuum

Additionally, our Aetna leadership team in West Virginia guides the Aetna Better Value team in developing a list of initial providers to approach that have large Medicaid patient panels, the capability to analyze mature data, and sophisticated reporting systems. We then use a 20-question survey to help determine where on our APM continuum a provider's capabilities fall and to gauge the provider's interest in participating in Aetna Better Value. Survey questions include the following:

- How many Aetna members are assigned to this practice?
- Do you have any pay-for-quality, PCMH, or shared savings (upside only/partial risk, full risk, capitation, bundled payments) in place with other Medicaid health plans?
- Do you employ care coordinators?
- Do you have after-hours/open access?
- Do you have an EMR, and if so, what is the name of the EMR?

- Do you have a patient portal available?
- Do you have licensed practical nurse/registered nurse/mid-level/behavioral health providers on staff?
- Do you have a physician champion?
- Do you use a registry to follow patients?
- Do you regularly receive and track specialists/consult notes on patients?
- Are your physicians compensated based on quality performance parameters?
- Do you have a legal entity that can distribute incentive funds to participants?
- Are you PCMH-recognized or certified by any organization?
- Are you part of an accountable care organization or clinically integrated network?
- Do you have a listing of community-based services? Do you regularly refer patients into community-based services?
- Are you familiar with stop-loss insurance?
- Do you carry stop-loss insurance?
- Do you have hospital privileges or a service level agreement with a hospitalist group? Which hospitals?
- Does the practice administrator regularly look at provider performance across cost, quality, and outcomes?
- How do you use data within your practice? Do you use predictive modeling software?

Survey results enable us to determine the ability of the provider to bear risk and the level of sophistication the provider has in data analytics and reporting—important factors in our decision regarding which APM to offer. A commitment to sustaining improvements by aligning goals with improved efficiency and quality is crucial to success. We also review the provider's use of care management systems and technology to support population health management, such as whether providers have an electronic health record system, care managers, and care coordinators on staff, relationships with pharmacists, relationships with ancillary care providers (e.g., home health), or experience with provider incentive programming related to population management. As the Aetna Better Value program matures, we continuously refine our approach to determine the optimal way to assess provider readiness.

Focusing on Social Determinants of Health for West Virginia

In addition to continuing to collaborate with providers to receive incentive payments, we are planning to enable providers to progress toward incentive payments for reporting valuable

information regarding the member's SDOH status. Aetna is working to address our members' social needs and the broader social determinants of health in the communities we serve. This includes societal and environmental conditions such as food, housing, transportation, education, violence, social support, health behaviors, and employment. Robust data related to members' social needs is critical to our efforts to improve the health of our members and communities. Aetna employs a standardized approach to screening, documenting, and coding social needs to enable us to do the following:

- Track the social needs that impact our patients, allowing for personalized care that addresses patients medical and social needs
- Aggregate data across patients to determine how to focus a social determinants strategy
- Identify population health trends and guide community relationships

One tool available to capture data on the social needs of the member population is the ICD-10-CM codes included in categories Z55 – Z65 (Z-codes), which identify non-medical factors that may influence a member's health status. Existing Z-codes identify issues related to a member's socioeconomic situation, including education and literacy, employment, housing, lack of adequate food or water, or occupational exposure to risk factors like dust, radiation, or toxic agents. Aetna will work with the Department and Centers for Medicare & Medicaid Services to investigate the use of Z-codes and consider opportunities to both increase data collection and utilization by the provider community.

In addition, our Care Connection teams communicate with providers and members about Aunt Bertha and our community-based services database. These tools assist us to connect members to community-based services to address any SDOH needs, such as transportation, food, housing, or employment. For example, we include 12 additional questions on our Health Risk Questionnaire to gain a more comprehensive picture of a member's SDOH needs. In addition,

we are working with Unite Us, a closed loop referral system, to connect members to services which address SDOH needs. The use of Unite Us coupled with the Care Connection team's personal knowledge of regional needs enables us to provide appropriate referrals that reduce SDOH-related barriers in accessing care.

Provider Satisfaction

PS008	The Vendor should describe its process to conduct annual provider satisfaction surveys to evaluate the overall satisfaction of its network providers, including the evaluation of results of satisfaction surveys on an annual basis, and how the Vendor will utilize data to inform quality improvement activities to enhance network satisfaction and availability of services to members.

The provider satisfaction survey assesses provider satisfaction with services that are important to the Aetna network of providers and their overall satisfaction with the health plan.

[PS008] Conducting Annual Provider Satisfaction

SPH Analytics (SPH), an NCQA-certified survey vendor, was selected by Aetna Better Health of West Virginia to conduct its 2019 Provider Satisfaction Survey. SPH followed a two-wave of mail and Internet with phone follow-up survey methodology to administer the provider satisfaction survey from July to September of 2019. A total of 345 surveys were completed (91 mail, 43 Internet, and 211 phone), yielding a response rate of 11.1 percent for the mail/Internet data component and 23.4 percent for the phone data component. Results include Aetna Better Health of West Virginia's composites and key attributes. Data and significance testing for trend years (if applicable) and the 2018 SPH Medicaid Book of Business are also provided for comparison.

2019 Aetna Better Health of West Virginia Provider Satisfaction Results show that **more than 90.7% of providers would recommend Aetna to other physician's practices**. This satisfaction result tops the 2018 Book of Business rate of 83.2%.

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Department for Health and Human Resources
CRFP 0511 BMS2000000002

The survey was administered to all participating providers who have been contracted with us for at least six months, including PCPs, specialists, and behavioral health care practitioners. Information obtained from the survey allows us to measure how well the health plan is meeting provider's expectations and needs. Based on the data collected, this report summarizes the results and assists in identifying plan strengths and opportunities These surveys address satisfaction with Aetna's utilization management procedures (prior authorization, concurrent review) claims processing and our response to inquiries.

The Provider Services department, in collaboration with Quality Management, Member Services, and administration support staff, coordinates satisfaction surveys. Comparison and analysis of results to prior Aetna results and national benchmarks provide information to identify areas that changed or require additional improvement. Aetna reports the analysis of results and applicable follow-up actions developed to address unfavorable results or trends to the Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC).

Evaluation of Results of Satisfaction Surveys and Informing Quality Improvement Activities to Enhance Network Satisfaction and Availability of Services

Our provider relations leaders review satisfaction results and share them with managers and directors to identify areas that may need corrective action. This group also determines plans of actions to initiate in order to improve the following year. Aetna uses a formal process to evaluate potential areas for improvement identified from member and provider surveys as well as other sources (such as member complaints, appeals, or physician incentive plans). Aetna prioritizes identified issues, addresses concerns, implements interventions, and reassesses issues to determine change in satisfaction. The formal process includes appropriate member and practitioner/provider communications and reporting to the Quality Management/Utilization

Management (QM/UM) Committee, QMOC, and the board of directors documented in committee minutes. For example, in 2017, survey results identified that providers were unsatisfied with our provider orientation process. Results showed that providers felt the process was not comprehensive and needed to include information about interacting with the health plan departments. Based on these findings, our quadruple aim action plan included developing a more comprehensive orientation process. In 2018, we created an enhanced Provider Orientation Toolkit that was sent to all new providers. We also began conducting monthly new provider webinars to enable providers to participate at their convenience. **We have experienced a 171.58 percent increase in provider orientation satisfaction scores from 2017 to 2019.**

Provider satisfaction is also incorporated into the CAHPS improvement plan. Aetna staff work to reduce provider burden and increase satisfaction through face-to-face visits, phone calls, webinars, web portal capabilities, gaps-in-care reports, and pay-for-quality programs. Care Management and Member Services staff assist providers in support of member access and satisfaction with care.

The latest CAHPS surveys indicate that members are satisfied with Aetna's provider network, including **Getting Needed Care, Getting Care Quickly,** and **How Well Doctors Communicate.** **Table 6.8.1-6** below shows Aetna West Virginia Medicaid child and adult members were satisfied with their ability to get needed care, tests, or treatment from our network of providers.

Table 6.8.1-6: Aetna 2018 and 2019 Child and Adult CAHPS Results Meeting the 75th and 90th Percentiles

CAHPS Measure	2018 Rate and Percentile	2019 Rate and Percentile
Child		
Getting Care Quickly Composite	94.83%/75th	95.92%/90th ▲
Getting Needed Care Composite	89.30%/75th	93.02%/90th ▲
How often did you get an appointment for your child to see a specialist as soon as you needed?	85.85%/75th	88.10%/90th ▲
How often was it easy to get the care, tests, or treatment your child needed?	92.75%/75th	97.95%/90th ▲
When you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?	92.55%/75th	93.68%/90th ▲
When your child needed care right away, how often did your child get care as soon as he or she needed?	97.11%/90th	98.16%/90th ▲
Adult		
Getting Care Quickly Composite Measure	85.14%/75th	86.74%/75th ▲
Coordination of Care	86.47%/75th	86.49%/75th ▲

We incorporate the CAHPS survey results to measure member satisfaction with our providers. Both NCQA Quality Compass® national Medicaid averages and NCQA percentiles are used to gauge plan performance. The 2019 NCQA Medicaid national average was made up of Medicaid plans that submitted data to Quality Compass in 2019. Member satisfaction percentage results were used to evaluate Aetna member satisfaction trends over time.

Provider Disputes, Appeals, and Reconsideration Requests

Another way that Aetna supports providers and evaluates provider satisfaction is by evaluating our NCQA Medicaid national average. This is an aggregate view of Medicaid plans that

submitted data related to performance during provider disputes, appeals, and reconsideration requests.

Provider Disputes and Reconsiderations

We administer an equitable, timely, and balanced review of provider disputes and reconsiderations as detailed in our Provider Dispute policy (WV-6300.00). Providers can call our Claims Inquiry Claims Research team regarding claim-related disputes or send them in writing to our Provider Relations department. Providers may also use Aetna's optional claim reconsideration form, which is on our website. The Provider Relations team responds to these concerns by phone, fax, email, or via the remittance advice if the claim is eligible for reprocessing.

Aetna's provider dispute process offers resolution when there is dissatisfaction between Aetna and the provider. Aetna will ensure that no punitive action is taken against a provider who files a dispute. A dispute between a provider and Aetna will not disrupt or interfere with the provisions of services to the member. Providers can send claims reconsiderations with supporting documentation to our claims team via the provider portal or by mail to the post office box in Arizona. Requests for claim reconsideration or claim resubmission that are received with a supporting claim at the health plan will be returned to the provider for filing with the claim copy to the post office box in Arizona for processing.

It is Aetna's policy that the resolution of issues regarding the interpretation of the state agency approved Aetna contract(s) is a matter solely between Aetna and the provider. Aetna will inform providers about this policy through the provider manual and other mediums, to include notices and alerts, training, provider orientation, and the website and by the provider calling their provider relations representative. Both contracted and non-contracted health care providers may

file disputes related to claim adjudication, claim payments, including resubmitted claims, issues related to coding, fee schedules, or contracting and health plan policies as provided by state regulations.

Aetna's decision is final for non-contracted provider claim disputes unless state regulations provide additional recourse. Aetna's provider relations representatives are available to discuss all provider issues. Upon receipt, they are classified as an inquiry or a dispute. A provider's dissatisfaction with an issue covered by this policy is considered a complaint and may be followed by the provider complaint and grievance resolution process as applicable. Any complaints received about health plan staff, contracted vendors, or members of the plan are classified as a provider complaint/grievance and will be automatically forwarded to the Appeal and Grievance department for processing as a provider complaint/grievance.

Dispute Process

To promote a quicker resolution process, the provider relations director or their designee reviews the content of the request, regardless of terminology used by the provider, and completes the triage process to determine the appropriate classification for processing. The provider may be asked to complete and submit the dispute form with any appropriate supporting documentation to the designated department listed on the form. The dispute form is accessible on our website, via fax or by mail. The provider relations director or their designee assigns the dispute form to a provider relations representative to research, analyze, and resolve. Aetna will notify the provider of its decision by phone, email, or fax or by surface mail.

Dispute Delegation

Requests for claim reconsideration or claim resubmission that are received with a supporting claim at the health plan will be returned to the provider for filing with the claim copy to the post

office box in Arizona for processing. Upon request any updates and/or changes to currently approved provider dispute processes will be submitted to the state agency for approval prior to the implementation of the changes, unless otherwise regulated by law.

Appeals

Aetna's provider complaint system offers an impartial process for resolving provider requests to reconsider a decision. A provider may file an appeal with Aetna. Aetna will respond to provider appeals pursuant to the guidelines in this policy. In addition, contracting providers may file an appeal directly with Aetna verbally or in writing regarding Aetna's denial or payment of a claim. Verbal request may be required to be submitted in writing. Aetna will make sure that no punitive action is taken against a provider who files a claim appeal. A dispute between a provider and Aetna will not disrupt or interfere with the provisions of services to the member. Aetna will administer an equitable, timely, and balanced review of provider appeal.

Responsibilities

Aetna's provider relations representatives are available to discuss a provider's dissatisfaction of an issue covered by this policy, and if the provider remains unsatisfied with a dispute resolution related to claim payment, the provider appeal process will be offered.

Aetna will make sure the following requirements are met:

- A dedicated Provider Relations staff is available for providers to contact plan via telephone, electronic mail, surface mail, or in person, to ask questions, resolve disputes, and file a provider appeal.
- Aetna will operate a provider access component of the toll-free telephone line to respond to provider calls.
- The provider access component of the toll-free telephone line will be staffed by Aetna provider representatives between the hours 8:30 a.m.to 5:00 p.m. Eastern time daily, excluding state holidays. Staff will answer the help line and respond to provider questions in all areas, including but not limited to prior authorization, provider appeals, and provider responsibilities.
- Aetna call center system will have the capability to track provider call management metrics.

Appeal Committee

The Appeal Committee is responsible for reviewing the appeal request and all supporting documentation. The committee is comprised of two or more staff members, which may include but not limited to the following:

- Appeal and grievance manager – chairperson (1 voting member)
- Compliance officer (1 voting member)
- Chief medical officer or designated medical director (1 voting member)
- Representatives from Quality Management and Utilization Management departments
- If clinical issue – staff registered nurse
- If clinical issue – physician with same or similar specialty
- Department managers and supervisors

Three voting members of the committee are assigned prior to each meeting. The voting panel will include individuals who were not involved in the original decision and who are not a subordinate to any person involved in the original decision. The appeal case is presented to the committee and a decision is rendered.

Communication of Complaint System Rights

Aetna will make the provider complaint system processes available to the provider through the provider manual and other mediums, including notices and alerts, training, provider orientation, the remittance advice, the Aetna website, in hard copy upon request (at no charge to provider) or verbally when the provider calls the provider relations representative. Any updates and/or changes to currently approved provider claim appeal process will be submitted to the Department for approval prior to the implementation of the changes. Aetna's provider appeal processes will remain unchanged during the Department review of new policies unless otherwise regarded by law.

Appeal Process

All Aetna staff who engage in provider contacting must understand the procedures for receiving, documenting, and forwarding a provider appeal to the Complaint and Appeal department. A

trained and qualified complaint and appeal analyst assumes primary responsibility for coordinating and managing provider appeals and for disseminating information to the provider about the status of the appeals.

Regardless of the department in which the information originates, all appeals are documented within Aetna's call system and submitted on the date of receipt, with supporting documentation, to the Complaint and Appeal department. The complaint and appeal analyst documents the appeal in the appeal and grievance application for tracking, review, referral, resolution, and reporting. Providers may submit an appeal either verbally or in writing. Verbal submissions may be required to be submitted to writing. Aetna will acknowledge all verbal requests verbally at the time of receipt and if requested will acknowledge written requests either verbally or in writing within three business days.

The Complaint and Appeal department is designated to receive provider claim appeals, documenting the substance of individual appeals, coordinating resolutions, tracking data, and reviewing appeals for trends in quality of care or other service-related issues. If the appeal requires research or input by another department, the Complaint and Appeal department will forward the information to the affected department and coordinate with the affected department to thoroughly research each appeal using applicable statutory, regulatory, and contractual provisions, where as appropriate, collecting pertinent facts from all parties and applying the Aetna's written policies and procedures. The appeal with all research will be presented to the Appeal Committee for decision.

The Appeal Committee will include a provider with same or similar specialty if the appeal is related to a clinical issue as well as an officer of the plan who has the authority to require

corrective action. Aetna will confirm that the individual(s) who makes decisions on appeals either individually or through appeal committee are individual(s) who were not involved in any previous level of review or decision-making and if deciding an appeal of a denial, reduction, termination, or suspension that is based on lack of medical necessity or an appeal that involves other clinical issues are health care professionals who have the appropriate training and clinical expertise, as determined by NCQA and the state agency, in the field of medicine treating the member's condition or disease or who has experience treating the member's condition or disease or treating similar complications related to the member's condition or disease. Same or similar is required for member appeals only. The Appeal Committee will consider the additional information and will decide the appeal.

The Complaint and Appeal department staff reports to the chief operating officer. All data collected is reported to the Appeal Committee, SIC, and QMOC at least quarterly (more frequently if appropriate) summarizing the frequency and resolution of all appeals for identification of opportunities for improvement as well as follow up on identified actions to address those opportunities. Appeals will be reviewed and resolved within 30 calendar days of receipt. The decision on verbal requests for appeal will be communicated to the provider via telephone no later than three business days after the decision is made. For all written requests, or requests where the provider requested a written response, Aetna will generate a written decision notice to the provider via electronic mail, fax, or surface mail within 10 calendar days from the date of the decision as promptly as the member's health requires. The timeframe for resolution may not be extended. Aetna will retain all appeals files in a secure, designated area for a period of at least seven years following the final decision.

9. Quality

The Vendor should refer to the business specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Quality (QU) as part of their bid. The Vendor's narrative response should not exceed 75 pages.

Aetna brings the full complement of our local and national quality improvement infrastructure to West Virginia to provide a comprehensive quality approach across the entire continuum of care to support the Bureau of Medical Services' (BMS) goal to ensure access to Mountain Health Trust (MHT), West Virginia Health Bridge (WVHB), and West Virginia Child Health Insurance Program (WVCHIP) enrollees. **Aetna was the first West Virginia Medicaid plan to achieve a Commendable National Committee for Quality Assurance (NCQA) accreditation as a Medicaid managed care organization and is the only plan to maintain it without interruption since 2016.** Our quality approach includes continuous quality improvement (CQI) activities with a performance improvement focus to meet West Virginia enrollee needs and preferences. **We are West Virginians and care about our neighbors,** which empowers us to make a significant impact in communities across the state, addressing our most vulnerable populations. Aetna has strong connections and collaborations with local providers and communities; through our Care Connection team (CCT) care management model, and with staff throughout West Virginia.

Aetna's Quality Assessment and Performance Improvement Program

QU001	The Vendor should describe its Quality Assessment and Performance Improvement (QAPI) Program.
QU002	The Vendor should describe how they will coordinate Quality Assessment and Performance Improvement (QAPI) activities with other performance monitoring activities.

QU004	The Vendor should describe how they will establish procedures for formal and ongoing communication and collaboration among the Quality Assessment and Performance Improvement (QAPI) policymaking body and other functional areas of the Vendor (for example, health services management and enrollee services).

Aetna's Quality Assurance and Performance Improvement (QAPI) program helps to support the State's goals by monitoring and enhancing the quality of care, coordination of care, and access to needed services for our enrollees. **Our quality management director is a West Virginia native and a registered nurse (RN) with over 30 years of quality management (QM) experience; she has been directly accountable for the quality program since 2014.**

"Working to pilot innovative health care solutions with Aetna Better Health has improved health outcomes and increased resources available to patients. In addition to the strong support from the Aetna team, our clinic benefits from equipment donations and shared savings plans. It's a pleasure to grow our relationship, learn from one another, and work collaboratively to improve lives with Aetna."

—Dr. C. Donovan Beckett, CEO Williamson Health & Wellness Center, Inc

[QU001] Quality Assessment and Performance Improvement Program Description

Aetna has a well-established QAPI program to direct organization-wide initiatives for continuously improving the health status of covered populations in compliance with the State Fiscal Year 2020 Model Purchase of Service Provider Agreement Section 6, 42 C.F.R. 438.330, and NCQA accreditation standards. The QAPI program is a health plan-wide endeavor that uses an integrated and collaborative approach **involving each functional area.** Integration of our QM activities with other systems, processes, and programs throughout Aetna has contributed to **many of our quality scores exceeding those of other plans serving West Virginians**. Our quality program includes a robust structure of oversight committees supported by our local and national resources, which include participation from contracted primary care providers (PCPs), specialists, and behavioral health (BH) care providers from the provider network representing the communities we serve. **Table 6.9.1-1** describes our local and national resources, in addition

to the West Virginia QM team, committed to supporting performance measurement, reporting, and data-driven initiatives.

Table 6.9.1-1: Examples of Local and National Resources Dedicated to West Virginia CQI

Resource	Description
Local West Virginia CQI Support	
Utilization management	Monitors performance trends in outpatient, inpatient, and ER utilization patterns, and generates over/under-utilization provider reports
Care management	Engages enrollees for closure of healthcare gaps and coordinates high quality care for enrollees with complex medical needs
Provider services	Facilitates interactions with providers, supplies gap in care reports, and coordinates Healthcare Effectiveness Data and Information Set (HEDIS®)/non-HEDIS provider education
Value based payment	Incentivizes providers to engage fully with our enrollees, provide needed services, and prevent over/under-utilization of services
Population health management	Outreaches to provider groups, reviews HEDIS rates, and discusses closure of gaps. Community health workers and peer support specialists provide enrollee education and link them to needed services
National CQI Support	
Aetna's National Medicaid IT team	Over 200 individuals dedicated to data management; they identify, connect, manage, and verify all data sources used in quality
Shared Services Informatics team	Performs HEDIS system oversight, data management, and quality reporting, as well as provider and value-based reporting that includes both HEDIS and utilization measures
Aetna Medicaid Organization's National QM team	Supports West Virginia team by reviewing HEDIS trends, developing new approaches to provider/enrollee engagement, conducting surveys and supporting scalable new approaches using industry-leading technology, analytics, software, and service companies.

QAPI Program Purpose

The primary purpose of the QAPI program is to provide the structure and processes necessary to identify and improve clinical quality, maximize safe clinical practices, and enhance enrollee, family, and provider satisfaction across the various settings of care within our West Virginia delivery system. Through our QAPI program, we ensure the services provided to our enrollees

conform to the standards and requirements of regulatory and accrediting agencies, including the Centers for Medicare and Medicaid Services (CMS), BMS, and NCQA.

QAPI Program Goals and Objectives

Aetna strives to achieve the following primary goals to help improve the health and social outcomes for our West Virginia enrollees:

- Implementing a QM program that effectively promotes a culture and infrastructure focused on continuous quality improvement, improving clinical outcomes, and enrollee satisfaction
- Conducting continual monitoring and assessment of enrollee care and services, striving to provide health care and services to health plan enrollees to ensure appropriate medical practice standards and that the needs of our enrollees and health care professionals are met
- Identifying and analyzing opportunities for improvement with careful implementation of actions and follow-up
- Encouraging enrollee safety across the organization and network of providers
- Maintaining compliance with local, state, and federal regulatory requirements and accreditation standards

Program Structure and Operations

Quality management activities that support the goals and objectives of the QAPI program are continually occurring at Aetna. Year over year, we analyze our progress in meeting established goals and push on to higher standards. **Aetna reviews, refreshes, and coordinates the goals and objectives of our QAPI program on a daily, monthly, quarterly, and annual basis.** The quality management program cycle is based on the calendar year. Our QM director makes interim modifications to QAPI program documents as needed or as state contract requirements change. Aetna's QAPI program is dedicated to communication and collaboration and is comprised of the QAPI Program Description, QAPI Work Plan, QAPI Program Evaluation, as well as policies and procedures.

QAPI Program Description

The QAPI Program Description outlines Aetna's strategic plan and goals designed to meet or exceed the West Virginia quality strategy, quality plan and other requirements of the Aetna

contract. Departmental staff reviews the QAPI program description at a minimum annually, revise it as necessary, and submit it for review and approval to the Quality Management/Utilization Management (QM/UM) Committee and the Quality Management Oversight Committee (QMOC). The board of directors provides the final approval of the QAPI program. We communicate QAPI program information and performance to enrollees on an ongoing basis through the biannual newsletter, which is posted to the website, including an annual summary of Consumer Assessment of Healthcare Providers and Systems (CAHPS) and enrollee complaints and our performance on NCQA requirements. We provide a summary of CAHPS and enrollee satisfaction performance annually to providers through provider alerts that are sent via fax/email and mail, as well as posted on our website under the Provider News tab at https://www.aetnabetterhealth.com/westvirginia/providers/library.

Annual QAPI Work Plan

The QAPI work plan is an activity-tracking tool used to facilitate achievement of quality management goals for the year. The work plan provides a timeline, schedules and description of deliverables and includes quality management and performance improvement activities including the QAPI, HEDIS, and CAHPS workplans, performance improvement projects (PIPs), and all CQI initiatives, resources, designated staff and/or department responsibilities, follow-up of previously identified issues, and progress towards completion. **The QAPI workplan is a living document and is updated as needed throughout the year as issues are identified.** For example, in the early third quarter of 2018, although we were meeting State requirements, through collaboration and communication between the QM and Utilization Management (UM) departments, Aetna made the decision to increase the reporting of turnaround times for UM decision-making from quarterly to monthly to ensure compliance with state contract

requirements. The QM staff updated the QAPI Work Plan for both 2018 and 2019 to reflect this change and to ensure timely reporting of this important UM metric to the Service Improvement Committee (SIC).

Annual Quality Management Evaluation
QM department staff coordinate a **company-wide annual evaluation of the QAPI program** to assess the overall effectiveness of our quality improvement program and alignment across the continuum of care. The annual program evaluation reflects an assessment of completed and ongoing activities as outlined in the QAPI work plan and described in the QAPI program description and includes the roles and responsibilities for each department. It also addresses barriers from the previous year and identifies barriers encountered during the calendar year, includes data trends, and provides Aetna with the opportunity to make changes to the quality management program for the upcoming year. For example, during the process of evaluating our results at the end of 2018, one barrier identified with the CAHPS survey was that it is only conducted once per year and does not allow any opportunity for open-ended comments or feedback from our enrollees. To address this barrier, Aetna implemented a post-call survey prompt at the end of every member call to the Member Services department beginning in the first quarter of 2019. This prompt offers members the opportunity to rate their satisfaction with that particular call to ensure resolution of the issue and also provides the opportunity for the member to provide comments regarding any issues that they may need assistance with. These ad hoc surveys allow for a

Based on Member Services post-call survey results, we identified ways to improve our services and go the extra mile for our enrollees. For example, based on feedback, we created a soft skills training for our member services representatives to improve their interactions with enrollees. Our member services representatives proactively help our enrollees by making outbound calls on their behalf or completing warm transfers for concerns such as billing and pharmacy.

more real-time method of gauging emerging trends in issues that members may be experiencing. Post-call survey results are reported to the SIC.

The evaluation includes all aspects of the QAPI program to determine the extent and effectiveness of improvements in the quality of care and services. We collaborate and communicate ongoingly with West Virginia enrollees, providers, and stakeholders through our QM/UM Committee (which includes network providers), our Member Advisory Committee (MAC), and the QMOC. Aetna reviews the annual evaluation and uses the findings to establish quality management and performance improvement goals for the upcoming year.

[QU002] Coordination of QAPI Activities with Other Performance Monitoring

Aetna integrates quality management and performance improvement processes into all departments, with each department responsible for selected processes, functions, and monitoring activities. QAPI activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of enrollee complaints and grievances. Staff members report results to the proper internal departments and committees, or to external agencies; QAPI activities are linked to other management functions such as network changes, benefit redesign, medical management systems, practice feedback to providers, enrollee education, and enrollee services. In order to ensure this coordination, Aetna has developed **nine Reaching for Excellent Accreditation for our Health Plan (REACH) teams** that are accountable for specific QAPI activities to identify areas of opportunity. The REACH teams include the following:

- **REACH Team 1, Quality:** QAPI Program Description, Work Plan and Evaluation; wellness and prevention, credentialing, interpreter services, and delegation oversight
- **REACH Team 2, Member Experience:** CAHPS and complaints and appeals (including appeal file review)
- **REACH Team 3, Care Management and Population Health Management:** Population health strategy, annual population assessment, and care management (including CM file review)
- **REACH Team 4, Coordination of Care:** Continuity and coordination of medical care, continuity and coordination between BH and medical care, and continued access to providers
- **REACH Team 5, Network:** Contracts, network adequacy, practitioner/provider supports, provider directory, and e-referrals
- **REACH Team 6, Utilization Management:** UM processes, timeliness reports, and UM file review (medical, BH), delegation of UM, and satisfaction with UM
- **REACH Team 7, Pharmacy:** Pharmacy NCQA Compliance workgroup including our QM leads, pharmacy director, and Aetna Medicaid organization pharmacy lead; responsible for pharmacy file review oversight, procedures for pharmaceutical management, and review of new technologies related to pharmacy
- **REACH Team 8, Communication Tools:** Member and provider tools, provider welcome letter, provider manual, Aetna member and provider websites, member newsletters, provider directories/DocFind, and new member welcome kit (materials only)
- **REACH Team 9, Member Connectivity Tools:** Member access to web-based technologies and Member Services email response monitoring and tracking

REACH Team Collaboration

REACH Teams 4 and 5 worked together closely to ensure that our process for member notification of provider terminations was implemented according to policy. Since the Provider Relations team is often first to learn of a provider termination, the REACH team collaboration allowed for direct communication between the Provider Relations team and the Member Services team to ensure that the steps in the process were followed. Our Provider Relations department receives the notification and advises the member services team to send letters out to members who are on the provider panels. Member Services is then available to assist members who may need assistance during this process. These teams work together to make sure this transition is completed accurately and timely within the 30-day window.

Each REACH team is responsible for ensuring compliance with all NCQA standards, including annual review of newly released standards; quarterly updates; and frequently asked questions. They hold regular and ad hoc meetings, as necessary, for barrier analysis, activity idea generation, and identifying system/reporting barriers, etc.

[QU004] Formal and Ongoing Communications and Collaboration among the QAPI and other Functional Areas

A formal committee structure allows for oversight of the QAPI program and for communication and collaboration between the policymaking body (QMOC) and other functional areas, as depicted in **Figure 6.9.1-1**. The committee members integrate Aetna medical functions, operations departments, network, and enrollees into the QM program through their participation on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements for QAPI and HEDIS. Our QMOC members, including Todd White, our chief executive officer (CEO), Greg Carpenter, our chief operating officer (COO), Tina Bailes, our chief financial officer (CFO), Donald Gibbon, DO, our CMO/medical director, and our director of quality management, director of medical management, compliance officer, and directors/managers from other functional areas within Aetna work together on a day-to-day basis on CQI efforts to ensure the QAPI program is integrated throughout the organization, among all departments, contractors, and stakeholders.

The QMOC reviews and evaluates company-wide performance monitoring activities, including care management, customer service, credentialing, claims, complaint and appeals, prevention and wellness, provider service, quality, population health management, and utilization management. As the chair of the QMOC and QM/UM committees, respectively, our CEO and CMO hold each functional area accountable for quality improvement activities.

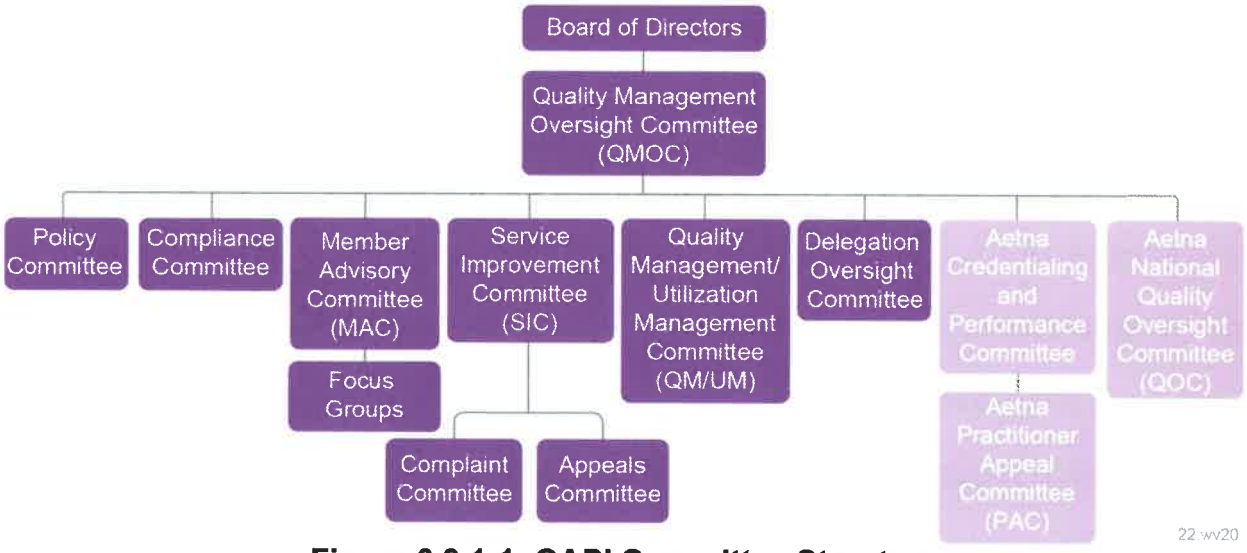


Figure 6.9.1-1: QAPI Committee Structure
Aetna's comprehensive quality committee structure directs organization-wide CQI initiatives.[1]

Board of Directors

Our board of directors is dedicated to the West Virginia plan and has ultimate accountability for the West Virginia QAPI program and related processes, activities, and systems. They review and approve the annual QAPI work plan and updates, program description, and evaluation.

Quality Management Oversight Bodies and Schedule of QM Activities

The keys to our QM strategy are communication and collaboration between Aetna departments and all key stakeholders. Our local West Virginia QM department provides the administrative support for coordination of committee meetings, meeting preparations, and follow-up activities. The QMOC provides executive oversight and proactive leadership of quality activities and their integration

At the April 2019 QM/UM meeting, a cardiologist on the committee recommended that Aetna consider the Prevention of Cardiovascular Disease Clinical Practice Guideline (CPG). Our CMO agreed and the provider presented the guideline at the May QM/UM meeting. The CPG was approved and posted to the Aetna website within a week.

[1] Aetna's local committees indicated in the dark purple color are supported by the Aetna national committees indicated in the light purple color

across the plan. **Table 6.9.1-2** provides a description of Aetna's local and national QM committees.

Table 6.9.1-2: QAPI Committees and Schedule of Activities

QAPI Committees	Description	Meeting Frequency
West Virginia-based Committees		
Quality Management Oversight Committee (QMOC)	Chaired by the CEO with cross-functional representation and oversight by the CMO; provides executive oversight of the QAPI program and makes recommendations to the board of directors about Aetna quality management and performance improvement activities.	Six times per year
Quality Management/Utilization Management Committee (QM/UM)	Chaired by the CMO/medical director with cross-functional representation (medical directors, behavioral health medical director, Quality Management director, Medical Management director) and West Virginia network providers representing all regions of the state, including PCPs, specialists, pediatrics, obstetrics/gynecology, and BH; advises and makes recommendations to the CMO/medical director on matters pertaining to the quality of care and service provided to enrollees.	10 times per year
Delegation Oversight Committee	Chaired by the director of quality management with cross-functional representation including the CMO, COO, Director of Medical Management, Compliance Officer, Member Services, Provider Services, and Complaint/Appeals departments); advises and makes recommendations to QMOC about delegated relationships.	Quarterly
Complaint Committee	Chaired by the appeals and grievances supervisor with cross-functional representation including the compliance officer, complaint and appeals analyst, member services, quality management, medical management, and provider services; reviews issues of expression of dissatisfaction by enrollees, practitioners, or providers.	Monthly
Service Improvement Committee (SIC)	Chaired by the COO with cross-functional representation; advises and makes recommendations to the QMOC and/or Aetna management using enrollee and provider feedback.	Monthly

QAPI Committees	Description	Meeting Frequency
Appeals Committee	Chaired by the appeals and grievances supervisor with cross-functional representation including the compliance officer, CMO, or designated medical director, utilization management, departmental supervisors and managers and staff RN; reviews appeal trends and may render decisions on administrative or benefit-related appeals.	Weekly
Member Advisory Committee (MAC)	Chaired by the manager of member services with cross-functional representation and member representatives; provides feedback to Aetna regarding strategies for improving member care and services. The MAC recommends strategies to improve clinical performance, cultural competency, member outreach and educational materials, prevention programs, satisfaction surveys, and other initiatives woven into the CQI process.	Quarterly
Compliance Committee	Chaired by the compliance officer with cross-functional representation including the CEO, COO, CMO, director of medical management, director of quality management, appeals and grievances supervisor, government liaison, quality management consultant(s), provider relations manager, and behavioral Health coordinator; reviews, monitors, and assesses the effectiveness of the Aetna compliance plan.	Quarterly
Policy Committee	Chaired by the compliance officer with cross-functional representation; development, implementation, approval, and communication of all Aetna policies including but not limited to clinical, non-clinical, and payment policies.	Monthly
Aetna National Committees		
Credentialing and Performance Committee (CPC)	Composed of participating providers of various specialties across the country, as facilitated by the Aetna regional medical director; responsible for credentialing and re-credentialing practitioners and conducting professional review activities involving practitioners whose professional competence or conduct adversely affect the health or welfare of enrollees. This committee reports to the QM/UM Committee at least quarterly.	At least every 45 days

QAPI Committees	Description	Meeting Frequency
Aetna Practitioner Appeals Committee (Subcommittee to the CPC)	Facilitated by an Aetna national medical director; conducts professional review hearings of providers who appeal decisions involving professional competence or conduct; consists of providers appointed by the CPC based on areas of expertise involved in specific professional competence or provider conduct appeals. The committee reports through CPC and to the QMOC.	As needed
Aetna National Quality Oversight Committee	Chaired by an Aetna national medical director or designee; conducts the credentialing/re-credentialing of facilities/organizational providers/vendors and the review of facilities/organizational providers/vendors issues and complaints.	10 times per year

Aetna takes part in all quality meetings as requested by the Department for Health and Human Resources (Department) to support the statewide quality goals, collaborate on initiatives, provide progress updates, and resolve barriers. We fully cooperate with the Department and External Quality Review Organization (EQRO) requests for all documentation.

Quality Management Department

Under the leadership of Aetna's Quality Management department in West Virginia, we have achieved a **Commendable rating from NCQA and an overall rating of 4.0 in 2019.** Under the direction of the West Virginia CMO, the QM department administers Aetna's QAPI and provides administrative support for health plan committees. The CMO reviews reports, data, and feedback from staff, providers, and members, identifies areas in need of attention, and submits recommendations to the appropriate committees and State agencies. The department is staffed with an **experienced local team that is knowledgeable of our State's communities** and includes our director of quality management, HEDIS manager and coordinators, accreditation project manager, Prevention and Wellness Outreach staff, and QM nurses.

Quality Management Department Responsibilities

The Quality Management department responsibilities include but are not limited to the following:

- Coordination and support of QM processes and monitoring activities to promote enhanced coordination of care, access to services, and seamless care for enrollees
- Coordination with Care Management, UM, Compliance, Medical Management, Behavioral Health including the behavioral health medical director, Customer Service, Member Services, Provider Services, and Complaint and Appeals departments to carry out quality and performance improvement activities
- Collaboration with the Aetna Medicaid organization's national QM team; including review of potential quality of care (PQOC) issues and best practices to improve HEDIS and CAHPS measures
- Design and implementation of performance improvement projects
- Monitoring performance rates for all performance measures across all departments through a CQI/ Plan-Do-Study-Act (PDSA) process
- Regular reporting of quality of care/service issues, trends, and issue resolutions
- Annual review and revision of the QAPI program; development and maintenance of the work plan
- Coordination of member satisfaction surveys including the annual CAHPS survey and the annual BH member satisfaction survey to promote tailoring flexible programs to meet member needs
- EQRO coordination

Quality management and performance improvement activities are part of a fundamental Aetna focus on ensuring enrollees' needs are met and systemic issues are modified to improve health and social outcomes. It is the central area for receiving and responding to potential quality and/or risk management and compliance issues. The department's role in initiating and coordinating communications is critical in linking the parties involved (enrollees, family/caregivers, practitioners/providers, state and regulatory agencies, and other staff members) and in keeping information about QM requirements and the status of activities current.

Wellness Events

Aetna's wellness events are designed to help our enrollees and their families achieve better health while forging stronger relationships with their health care providers. We collaborate with providers to hold these events for our members who are overdue for a specific service or exam they need. Aetna staff conducts member outreach by scheduling appointments, sending

reminder letters, making reminder calls, and meeting with the members directly after their exam to provide them with a $25 Walmart gift card. Aetna staff who attend the events address any questions or issues the member may have with their benefits and discuss their healthcare needs and goals with one of our CMs. As an added benefit, while talking with our members at these events, we ask who they consider as their PCP. We use this information to update our PCP member rosters. As illustrated by **Figure 6.9.1-2,** Aetna currently offers several event types.



Figure 6.9.1-2: Aetna Wellness Events
During 2019, the QM team hosted 25 different wellness events at 20 different provider locations across the state. Member and provider satisfaction with these well-visit member engagement events is exceedingly high and the events will continue into 2020 and beyond.

Behavioral Health

Ongoing communications and collaboration among our functional areas also allows integration of quality management BH activities into the QAPI program. As one example of our proactive

approach to BH, we developed and outlined in our QAPI program our Care Management initiative to outreach all new moms after delivery to screen for postpartum depression. Any new mom who screens positively for possible signs/symptoms of postpartum depression is referred for an appointment with a BH provider. The Care Management staff member assists the new mother in obtaining the appointment and offers other assistance across the spectrum of health, and also assists with transportation. This type of program is partly due to our **QM/UM Committee, of which one third of the network providers are BH practitioners.** This real-time collaboration between PH health and BH clinicians on a monthly basis provides valuable feedback regarding current and planned QM activities and promotes the collaboration between all Aetna departments to facilitate seamless continuity of care between PH and BH practitioners. Another example of this collaboration includes working closely with network hospitals and providers to confirm that enrollees hospitalized with a BH diagnosis receive a timely follow-up appointment at discharge. Our program conducts an outreach call as soon as we see a member has been discharged from a mental health admission, and we continue calling using any member contact information on file with the facility if needed. If unreachable by phone, we will send a letter. **As a result, our HEDIS rate for 7-day follow-up visits went from the 10th percentile in HEDIS 2017, to the 33.33rd percentile in HEDIS 2019.**

Quality Strategies and Approach

QU011	The Vendor should describe how they will develop standards of performance when providing healthcare and related services to members to meet all goals for performance improvement on specific measures, as established by the Department.
QU012	The Vendor should describe its approach to developing performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Projects must measure performance using

	objective quality indicators, implement system interventions to achieve quality improvements, evaluate the effectiveness of the interventions, and plan and initiate activities for increasing or sustaining improvements.
QU013	The Vendor should describe how they will establish and utilize one or more quality indicators that are objective, clearly, and unambiguously defined, and based on current knowledge or health services research, to assess its performance.

As required in State Fiscal Year 2020 Model Purchase of Service Provider Agreement Section 6, our quality strategies and approach include the following:

- Annual measurement of performance in specified areas (e.g., immunization rates) and achievement of performance targets
- Multi-year PIPs addressing clinical and non-clinical areas
- An approach for addressing systematic problems and critical incidents
- The development and usage of a sufficient health information system
- Proper administration of quality assessment and performance improvement activities

[QU011] Developing Standards of Performance to Meet Goals

Aetna develops standards of performance when providing health care and related services to members to meet all goals for performance improvement on specific measures, as established by the Department through our ongoing CQI approach. In addition to meeting the goals and minimum performance standards established by the Department, we enhance the scope, goals, objectives, structure, staffing, and responsibilities of the QAPI program based on our analyses, historical performance, benchmarks, and best practices, as well as changes to the contract and accreditation standards to address specific regional needs of our enrollees. **Even when we meet State HEDIS goals, we set a new higher goal as part of our CQI process, using a statistically sound algorithm to calculate the next goal to achieve.**

Aetna leadership, providers, members, and member agency representatives, community agencies, and multiple departments work together as a team to set our organization's performance goals. We evaluate performance improvement on specific measures monthly, quarterly, and annually through our quality committees. Our CQI approach to goal-setting

encompasses an extensive array of activities, involving providers, members, their families/caregivers, and operations teams. PDSA guides our approach to developing, testing, implementing changes, and ultimately, setting the goals used in our QAPI program and PIPs. This is shown in our workplans where areas for potential improvement and corresponding actions are documented as guided by our QM/UM Committee.

[QU012] Performance Improvement Projects

Our Quality Management department responsibilities include development of PIPs in collaboration with the Department in compliance with requirements outlined in the State Fiscal Year 2020 Model Purchase of Service Provider Agreement.

Aetna scored 100 percent on every PIP audit conducted by the EQRO for measurement year 2018 (reported August 2019).

We design projects to achieve significant improvement in the quality or appropriateness of clinical and non-clinical service provision to improve health outcomes and enrollee satisfaction. We identify PIP topics from areas of importance or weakness identified by regulators or through our internal monitoring processes and committee recommendation.

To design a PIP, we examine relevant regional and state-focused clinical and non-clinical information, including enrollee/provider satisfaction, financial, demographic, utilization of services, or other factors that impact enrollees, providers, or the larger community. When not specified by a regulator, selection of PIP activities can take into account the prevalence of conditions among

Improving Care for Adolescents

In 2020, Aetna will be implementing a new PIP focusing on care for adolescents. This is typically a difficult population to engage in health care. The two indicators for this project will measure immunization rates in adolescents and the percentage of adolescents who are receiving timely well-care visits. Current performance indicates an opportunity for improvement, as the current Aetna rate for adolescent immunization is below the 25th percentile. Additional staff are being added to focus on outreach to our child and adolescent population to encourage them to attend well-visit appointments. Our targeted actions for improvement will include members in the new WVCHIP population.

enrollees, the need for specific services, identified barriers to service, demographic characteristics, identified racial disparities, and health risks among enrollees or the community served by Aetna in West Virginia.

The goal of each PIP selected is to achieve statistically significant improvement and to sustain the improvement over time. Each PIP includes performance objectives that are objective, measurable and outcome oriented. Evaluation and analysis of the data, including the data's source, ensures it is appropriate to answer the study questions. Data sources are evaluated to assure they reflect the most currently available data and the data reflects national and/or community standards of care. We initiate and maintain at least three simultaneous projects selected by the Department or through our internal selection processes. All of our PIP proposals are approved by BMS and the EQRO prior to implementation. As examples, our dental services for children and adolescents and postpartum visits PIPs are highlighted below.

Improvement in Dental Services for Children and Adolescents

A key preventive care initiative for Aetna has been our focus on improving dental care for children and adolescents throughout West Virginia. We identified our objective quality indicator of annual dental visits for children age 2 to 20 years in 2017 (61.04 percent) as an area for potential improvement. Our collaborative approach included review and input from multiple departments to create an intervention with efforts across each team's scope of activity. For example, our Care Management team focused upon addressing gaps in care as they work with children and adolescents in various levels of care management. Similarly, our QM department's Data Analytics team pinpointed geographical regions within the state where the dental visit rates were lower than the overall average. With the assistance of our Provider Relations team, we collaborated with provider offices in these lower-performing areas to host dental clinics, where

parents and guardians who agreed to bring their children were given a $25 gift card for completing the visit. The dental well-clinic days were well-received, as depicted in **Figure 6.9.1-3**. Our Community Development team focused attention on the importance of dental visits during their back-to-school events in various communities across the state. We collaborated with Head Start programs in Raleigh, Mercer, McDowell, Monroe, and Wyoming counties to highlight the importance of dental screening visits. **As a result, our dental visit rate showed a statistically significant increase from 61 percent in 2017 to 64 percent in 2019, and this improvement was sustained across both years.**



Figure 6.9.1-3: Dental Visit
Ariel (not her real name) is happy with her Aetna backpack full of goodies provided during the children's dental event at Williamson Health and Wellness Center.

Improvement in Postpartum Care

Regularly scheduled postpartum visits are essential to the well-being of our new mothers and infants. Postpartum visits offer the new mother and her provider time to assess her physical condition, screen for postpartum depression, and discuss infant care and family planning. Aetna's West Virginia QM team evaluated various cultural and disparity factors that may be affecting this postpartum visit rate. We identified that 222 (28.5 percent) out of 780 women who had not kept their postpartum appointment had an opioid use disorder. These new mothers tend to keep their appointment with their BH provider for the substance use disorder (SUD), but not the appointment for the postpartum checkup. Identification of this association presented an opportunity to engage the Care Management team for enrollee outreach and assessment. Aetna embedded obstetrics care managers at hospitals, high-risk clinics, and provider offices across the state to work with

our pregnant mothers during the pregnancy to educate them on the importance of postpartum care. The CCTs in each region of the State are uniquely positioned to work face-to-face with enrollees in their communities to assist with postpartum care planning. The SUD nurse team member of each of the CCTs is vital to addressing those issues of SUD in our pregnant mothers. Member incentives, including a $50 gift card for attending the postpartum visit, are offered to encourage compliance. We measured performance of this initiative through three objective quality indicators:

- **Prenatal and Postpartum Care – Postpartum Care:** The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery
- **Behavioral Health Risk Assessment – Modified:** The percentage of women, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a BH screening risk assessment at one of their prenatal care visits
- **HEDIS Like – Postpartum Care:** The percentage of deliveries that had a postpartum visit at any time prior to 21 days after delivery or after 56 days.

Using Lessons Learned, Challenges, and Successes

Our QM team has several long-standing staff that worked for Aetna in collaboration with the Department and EQRO since the first PIP proposals. We gain most of our understanding of lessons learned, challenges, and successes through PIP planning sessions, from provider and enrollee feedback, as well as open discussions through collaborative meetings between Care Management and Quality Management staff. For example, in conducting our barrier analysis for the dental PIP, we learned that there was opportunity for improved collaboration between Aetna and the dental vendor, SKYGEN USA, in order to identify additional dental providers who would see children as young as age two. Through ad hoc discussions with SKYGEN USA as well as during our quarterly Joint Operating Committee (JOC) meetings with them, we identified participating dentists available to see our younger members. Additionally, it was discovered in conversations with pediatricians, as well as with SKYGEN USA, that there seemed to be an

issue when PCPs were attempting to assist the enrollee in finding a dentist for care. Dental providers seemed to have questions about scheduling an appointment for a member with Aetna Medicaid organization coverage, and instead seemed to recognize SKYGEN USA as the benefit administrator. The Aetna Provider Relations team has begun working with provider groups to offer suggestions for mentioning SKYGEN USA in the request for a dental appointment to decrease confusion.

[QU013] Establishing and Utilizing Objective Quality Indicators

Continuous quality improvement is core to the success of Aetna's quality programs. We select specific quality indicators to measure changes in West Virginia enrollee health status, functional status, and/or satisfaction based on the most current information available, including national and/or community standards of care. We are constantly improving our services and processes with a focus on West Virginia enrollee outcomes and satisfaction. We design targeted initiatives to achieve demonstrable improvement and to sustain the improvement over time; each improvement activity includes performance objectives that are measurable and outcome oriented. We require the quality indicators to be objective and clearly and unambiguously defined as outlined in **Table 6.9.1-3**.

Table 6.9.1-3: Examples of Aetna's Quality Indicators

Description of Initiative	Quality Indicator	Rationale for Selection of Quality Indicator
Annual Dental Visit for Members Age Two to Three Year	• Percentage of Eligibles that Received Preventative Dental Services (PDENT) • Annual Dental Visits Ages 2-3 (ADV)	National research from the Centers for Disease Control and local West Virginia statistics
Prenatal Behavioral Health Risk Assessment	• **Prenatal and Postpartum Care – Postpartum Care:** The percentage of deliveries that had a postpartum visit	National research on America's Health Rankings and local

Description of Initiative	Quality Indicator	Rationale for Selection of Quality Indicator
and Postpartum Care Visit	on or between 21 and 56 days after delivery • **Behavioral Health Risk Assessment – (modified):** The percentage of women, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a BH screening risk assessment at one of their prenatal care visits • **HEDIS Like – Postpartum Care:** The percentage of deliveries that had a postpartum visit at any time prior to 21 days after delivery or after 56 days	West Virginia performance on metrics
Annual Monitoring for Patients on Persistent Medications	Annual Monitoring for Patients on Persistent Medications – Total Rate	National literature review, national research from the Food and Drug Administration (FDA) and local West Virginia statistics and performance
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	The percentage of ER visits for enrollees 13 years of age and older with a principal diagnosis of alcohol or other drug abuse (AOD) or dependence, who had a follow-up visit for AOD within 30 days of the ER visit	National research from the Centers for Disease Control and local West Virginia statistics

We use proven statistical methodologies in designing and evaluating performance improvement activities, taking significant effort to provide accurate and reliable data. Evaluation and analysis of the data source ensures it is appropriate to answer the study questions and is the most current available. Aetna's assessment of data and potential for improvement is supported by sophisticated technology, databases, and tools to collect and analyze all available information and ensure its reliability. This includes our claims management system, HEDIS NCQA-certified

software, hotspot analytics platform, medical record audit repository, grievances and appeals system, pharmacy data system, and member-specific information from our health risk questionnaire surveys and case management assessments.

Data Gathering and Oversight

QU009	The Vendor should describe how they will gather, report, and utilize audited Healthcare Effectiveness Data and Information Set (HEDIS) measures.
QU010	The Vendor should describe how they will gather and use results for all identified core adult and child quality measures relevant to covered services to identify opportunities to improve member health outcomes, following the technical specifications provided by the Centers for Medicare & Medicaid Services (CMS) (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html), (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html).
QU015	The Vendor should describe its policies and procedures to correct and remediate significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

Aetna uses HEDIS, core adult and child quality measures, and other performance indicators to assess our program and policy impact on our enrollees. We closely monitor and immediately address all system problems that come to our attention.

[QU009] Gathering, Reporting, and Utilizing Audited HEDIS Measures

Improving HEDIS or other performance-indicator rates is a company-wide endeavor, with operating responsibilities shared by departments designated by the CEO. The Quality Management department HEDIS responsibilities include the following:

- Leading initiatives for improving the performance of each HEDIS metric using a CQI/PDSA approach
- Incorporating the gathering, reporting, and utilization of HEDIS measures into the QAPI workplan
- Review and oversight of data collection, document review, inter-rater reliability assessments, and measurement reporting

Aetna has steadily increased our HEDIS Well Child Visits in the First 15 Months of Life (W15) score in West Virginia from HEDIS 2017-HEDIS 2019 from the 50th to the 75th to the 90th percentile. In HEDIS 2019, our rate was 73.24% compared to West Virginia Medicaid competitors scores of 68.25% and 65.94%.

- Participating on the EQRO oversight team, as applicable, to coordinate review and attestation of data integrity and preliminary and final results by the Aetna CEO, CMO, and HEDIS coordinator

Aetna has a proven capacity to participate in the annual HEDIS and non-HEDIS performance measurement and reporting initiative as evidenced by our timely submission in West Virginia to NCQA and state regulatory agencies for HEDIS 2016, 2017, 2018, and 2019. At the close of each review cycle, our contracted NCQA auditor validates our HEDIS data files. Aetna has demonstrated superior HEDIS scoring, as depicted in **Table 6.9.1-4**, with examples of our HEDIS scores above the national average.

Table 6.9.1-4: Examples of Aetna West Virginia 2019 HEDIS Scores above National Average

Measure	National Average	HEDIS 2019
Child Measures		
Adolescent Well Care	53.20%	61.31%
Annual Dental Visit – Total	55.88%	64.18%
Asthma Medication Ratio 12 to 18 years	65.44%	73.91%
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication – Continuation and Maintenance Phase	54.63%	63.43%
Immunizations for Adolescents—Combo 1	79.19%	85.16%
Medication Management for People with Asthma 5 to 11 Years	31.76%	44.07%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total	35.25%	63.06%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Total	67.32%	79.81%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Total	62.39%	73.97%

Measure	National Average	HEDIS 2019
Adult Measures		
Controlling High Blood Pressure (CBP)	58.86%	66.91%
Comprehensive Diabetes Care (CDC)		
HbA1c Poor Control (>9.0%) (inverse measure)	41.15%	36.01%
HbA1c Control (<8%)	48.74%	52.07%
Blood Pressure Control (<140/90 mm Hg)	62.15%	71.05%
Follow-Up After Hospitalization for Mental Illness (FUH): Total – 30-Day Follow-Up	56.79%	56.92%
Use of Opioids from Multiple Providers (UOP): Multiple Prescribers and Multiple Pharmacies (inverse measure)	4.82%	3.02%
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	81.54%	87.10%

Aetna has steadily increased our WCC Nutrition score in West Virginia from HEDIS 2017 to 2019 from the 50th to the 66.67th to the 75th percentiles. In HEDIS 2019, our rate was 79.81% compared to competitors scores of 72.99% and 67.88%.

Aetna closely tracks HEDIS performance in our HEDIS workplan, and we incorporate HEDIS activities and performance measurement goals into the annual QAPI work plan. Analysis and comparison of performance results to national benchmarks provides the basis for the design and implementation of appropriate interventions. If Aetna does not meet targeted goals, the QM department develops a corrective action plan (CAP) and submits to the CMO/medical director and leadership for review, and to track and trend measures. We recognize the positive effect of aligning provider and member incentives to drive performance improvement results.

As one example, **we increased the diabetic eye exam rate by 12 percentage points from 2017 to 2019** through the following:

- Making outreach calls to members by our QM staff to remind them of the importance of the diabetic eye exam; many times, the member was not aware that the diabetic eye exam was a covered benefit since there is no adult vision benefit; during 2017, we completed 445 successful member outreach calls to encourage diabetic eye exams with 947 outreach contacts completed in 2018
- Making gaps in care calls from the Care Management staff to their members enrolled in care management to remind them of the importance of the diabetic eye exam
- Offering community diabetic eye exam wellness events hosted at various provider locations including federally qualified health centers (FQHCs) across the state, where QM staff are in attendance to hand-deliver the incentive gift card that the member earns by having the diabetic eye exam
- Implementing a provider incentive for diabetic eye exams in early 2018
- Purchasing retinal cameras for two FQHCs (Williamson Wellness Center and Partners in Health)

Aetna shares results across departments to maximize member benefit; one example of this is the sharing of the HbA1c Poor Control (>9.0 percent) member level data with Care Management staff. Care Management staff outreach to all of the identified members to support them in engaging in services. As a result, HbA1c Poor Control (>9.0 percent) improved by three percentage points.

Of the 25 wellness events Aetna held in 2019, 10 were well-visit drives and 6 were dental events. We saw an improvement in our W34 HEDIS score from 66.8% in November 2018 to 69.1% in November 2019 (preliminary); our HEDIS AWC score improved from 45.1% to 47.9%.

A key element of our strategy to impact outcome measures in children is our focus on increasing engagement with the PCP. The QM team collaborates with PCPs across the state to host well-visit drives at the provider office. Prior to the event, QM conducts telephone outreach to members to invite them to the office for the well-visit, at which time the member will receive their well-care incentive gift card for attending the event. During 2019, the QM team hosted 25 different wellness events at 20 different provider locations across the state. Member and provider satisfaction with these well-visit member engagement events is exceedingly high and the events will continue into 2020 and beyond. The Aetna HEDIS team keeps all departments

and staff notified of the progress on HEDIS measures through posting and distribution of a thermometer-style graphic for key measures as depicted in **Figure 6.9.1-4**.

[QU010] Gathering and Using Results for Core Adult and Child Quality Measures

To best measure performance improvement and member outcomes, Aetna gathers and utilizes a variety of measures from both NCQA (HEDIS) and the core adult and child quality measures following the technical specifications provided by CMS. We have been providing all applicable information to our software vendor to produce the CMS core adult and child rates for the State of West Virginia. We incorporate these rates into our QAPI and CQI processes for targeted improvement initiatives. Examples of core only measures we gather and use results from include but are not limited to the following:

- Asthma in Younger Adults Admission Rate
- Contraceptive Care Postpartum Women Ages 21 to 44
- Screening for Depression and Follow-up Plan
- Congestive Heart Failure Admission Rate
- COPD or Asthma in Older Adults Admission Rate
- Diabetes Short-Term Complications Admission Rate

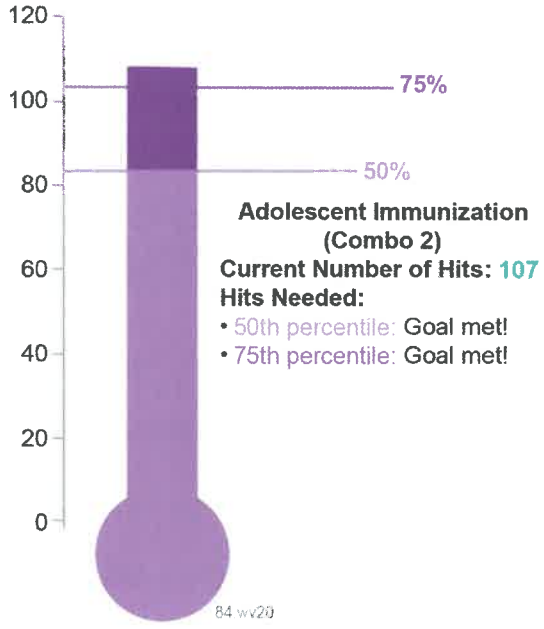


Figure 6.9.1-4: HEDIS Metric Progress
Our HEDIS team translates current rates into a thermometer concept, an easily recognizable way to indicate performance relative to the goal, to allow staff to visually track progress.

As one example of how we gather and use results from adult and child core measures, we closely monitor, track, and trend the child core measure Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH) Administrative (Form CMS-416). We recognized

opportunities for improvement in this measure and used this information for our PIP and

implemented interventions to improve the rate, including the following:

- Provider:
  - Collaboration with dental vendor to recruit additional dentists who will see Medicaid members
  - PCP annual dental visit (ADV/PDENT) provider education
  - High-volume practitioner ADV incentive: Provider incentives offered to our high-volume practices. to earn higher-dollar rewards for reaching 'stretch goals' for this measure
  - Provider well-child $25 incentive: We send all PCPs a list of their members who are at least 12 months since their last well-child visit. Providers are encouraged to reach out to the members to encourage them to schedule appointment. QM staff then monitor claims and send the incentives out on a quarterly basis.
- Member:
  - Promotion of free transportation
  - Ted E. Bear, M.D.[SM] Cub Club: Being a member of this club means each child will get special offers to complete healthy activities to win fun prizes. These healthy activities include well visits, dental visits, immunizations, and healthy behavior activities and challenges. Dental is new for the Cub Club in 2018: Seasonal Dental Challenge. Members participate in toothbrushing two times a day, two minutes each time for three months. At completion, members receive a dental kit which includes toothbrush, toothpaste, and floss.
  - Member well-child visit $25 incentive for ages 12 to 18
  - Dental wellness community events/clinics
  - Community Development Program: Hosts and/or attends many community events where Aetna provides dental education and toothbrushes; enrollee data is incorporated when possible to target areas to hold community outreach events
  - Gaps in care outreach (ADV)
  - Pregnancy dental benefit: The dental benefit for pregnant women provides additional benefits for dental services for pregnant enrollees to include two cleanings and one exam per pregnancy
  - Diabetes Dental Program: The Diabetes Dental Pilot Program is for Type II diabetic members age over 21 years in approximately 20 counties (Calhoun, Gilmer, Grant, Hampshire, Harrison, Jackson, Marion, Mason, Mineral, Mingo, Monongalia, Pleasants, Preston, Randolph, Ritchie, Roane, Taylor, Upshur, Wetzel, Wirt, and Wood). This intervention targets the barrier of caregiver/parent poor oral health and the potential considerable impact that poor caregiver(s) oral health and dental care may have on their children receiving needed dental services. We recognize that the benefit of one member of a family learning about the importance of good dental care can impact each member of their family's care, including their children. CMs contact enrollees and refer to a dentist for oral health assessment, dental visit, periodontal cleanings, scaling, and debridement. CM contact is on a quarterly basis, or more as needed or if identified as intensive CM. Members also receive an electric toothbrush as part of the program.
  - Member geographical data analysis

- Member complex health condition/special health care needs data analysis
- Neonatal Abstinence Syndrome (NAS) Program: There were 150 new members enrolled in the NAS program in 2018. This targets the potential barrier that the presence of NAS and/or history or NAS and continuing substance use environment could affect oral health and access to dental care, and this does appear to be a risk factor. The NAS CM program follows the mother through prenatal and postpartum periods, as well as the baby and mother one year after delivery. This could considerably impact the ADV two- to three-year indicator, providing intervention to the member and mother/family within the first year after birth, and then potentially carrying positive behaviors through to the PDENT ages as well.

[QU015] Correcting and Remediating Significant Systemic Problems

Aetna has established policies and procedures to correct and remediate system problems identified through internal surveillance, complaints, and other mechanisms including but not limited to the following:

- Quality of care review
- Peer review process
- Enrollee complaints and appeals
- Continuity and coordination of care monitoring
- Medical records review
- External quality review

Quality of Care Review

Aetna's integrated quality review process ensures that issues involving quality of care or service, safety, complaints, or other areas of dissatisfaction are promptly and systematically evaluated. We require any employee who perceives a potential quality, risk management, or safety issue to refer the issue to the Quality Management Department.

Proactive Monitoring for Enrollee Safety

Our pharmacy director monitors for any Class I drug recalls for the drugs that we manage. If we have members or providers who were impacted by the recall, we send them written notification. A quarterly report of this activity is presented to the QM/UM Committee. At the January 22, 2020 QM/UM Committee meeting, the pharmacy director presented the year-end summary for 2019. We had six Class I recalls in 2019 and four of them had members and providers that were impacted. Aetna notified these members and providers within 30 days of the recall issued by the FDA.

Quality management nurses review and assign a different functional area within the organization to review and address the needs as indicated. All PQOCs are reviewed by a medical director and may be referred to the QM/UM Committee for review and recommendation. To help

address systematic issues, the centralized PQOC team document and track and trend PQOC issues in our PQOC business application system. The West Virginia HEDIS manager and QM nurse consultant meet with the nurse assigned to PQOCs every two weeks with a quarterly high-level summary shared with the SIC, where identified trends are presented. The inclusion of a nurse from the national Medicaid team in the PQOC process allows us to better identify and coordinate PQOCs involving our providers who may be caring for Aetna enrollees in bordering states like Kentucky, Ohio, Pennsylvania, and Virginia. When a significant trend is identified, it is referred to the National Quality of Care (NQOC) committee

Peer Review Process

Aetna utilizes a well-documented peer review process to monitor and evaluate potential quality, risk, or service issues that occur during the provision of care or services to a health plan enrollee. Aetna policies and procedures describe the peer review/appeal process and the actions Aetna may take upon identification of a quality issue. Such actions may include, but are not limited to, development of a CAP with a description of the timeframe for improvement; evidence of education, counseling, development of policies and procedures; monitoring and trending of data; and limitation or discontinuation of the provider's contract with the plan.

The peer review process focuses on the issue identified, but if necessary, could extend to a review of utilization, medical necessity, cost, and/or health provider credentials as well as other quality issues. The Quality Management department coordinates peer review activities although they often require the participation of Medical Management, Provider Services, or other departments. Aetna requests external consultants with relevant clinical expertise and experience (e.g., in oral surgery, cardiology, oncology) to participate in peer review activities, if

applicable. The CMO or designated medical director oversees the peer review investigation of issues referred in accordance with 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 and/or Aetna Credentialing and Performance Committee for review and recommendation
- Analysis of identified issues for tracking and trending
- Reporting of findings to designated committees at least annually
- Notification by Aetna to the appropriate regulatory board or agency if a provider's contract is terminated, suspended, or limited due to quality of care issues
- Development and implementation of CAPs as necessary
- Fair Hearing rights for providers

Member Complaints and Appeals

Aetna is committed to improving member experience and satisfaction with health care, providers, and services. To assess member satisfaction, Aetna utilizes member complaint and appeal data maintained through a complaint and appeals system that enables members, or providers acting on their behalf, to express dissatisfaction with services provided. Regardless of the department from which the information originates, all complaints and appeals are documented within Aetna's operating systems and submitted on the date of receipt, with supporting documentation to the Complaint and Appeals department for review, referral, resolution, and reporting. This allows critical analysis to identify systemic issues and the source of those issues.

Of the 164 member appeals received in 2018, 100% of non-urgent pre-service appeals were resolved within the 30-calendar day turnaround time. Ninety-nine percent of urgent/expedited appeals were resolved within the 72-hour turnaround time. This percentage increased from 96% in 2017, allowing the plan to meet Aetna internal turnaround time goals.

The appeals process addresses denied claims or other services relative to a member's benefits. Complaints and appeals are categorized, analyzed, and presented during regularly scheduled committee meetings where Aetna identifies opportunities for improvement, monitors trends, and

develops action plans for our West Virginia enrollees. This comprehensive analysis of member complaints and appeals is performed and reviewed by multidisciplinary committees that includes the Member Services, Provider Services, Complaint and Appeals, Quality Management, and Network Management departments. An annual analysis is performed in order to determine systemic root causes, identify potential barriers, and improve plan performance and reported to the SIC and QMOC.

Continuity and Coordination of Care Monitoring

We are West Virginians; our local experience augments our ability to assure continuity and coordination of care for West Virginians. Aetna recognizes the importance of maintaining continuity of care and service whenever an enrollee's care setting or provider changes. Aetna integrates processes to guard against interruptions in our West Virginian enrollees receiving needed care into Aetna systems and departmental processes. Integrated systems and interdepartmental processes include, but are not limited to, the integrated business application system, which is accessible by all departments involved in coordinating services for an enrollee. The system allows departments to share enrollee, practitioner, and provider information, to coordinate procedures such as discharge planning, transitioning an enrollee from an institutional setting back into the community, authorization of post-hospital services, and follow-up on complex cases or emergency room care.

Aetna maintains policies and procedures for monitoring the services West Virginia enrollees receive during transitions, between health plans and during transitions within Aetna from one practitioner or ancillary provider to another. During such transitions, enrollees identified with high-risk conditions or special needs are monitored to ensure maintenance of the previous level of care and/or service. Aetna identifies enrollees for assignment to care management through the HRQ, Consolidated Outreach and Risk Evaluation (CORE™) member stratification tool, or

surveillance. Additionally, Aetna may receive referrals from community partners or internal sources who, through their day-to-day work with current Aetna members, identify individuals that could benefit from a higher or different level care management services than the level they are enrolled in. The Member Services department is available to assist members in selecting or changing their PCP assignment and identifying participating specialists in their area. Aetna's Care Management staff assist members in coordinating needed services during a change in the member's level of care (i.e., integrated care management model).

Using the PH and BH integrated model, Aetna collaborates with participating BH specialists in West Virginia to monitor and improve coordination between PH and BH care for individuals with complex care needs. Aetna has built a sense of collaboration between the health plan and the BH providers as well as the promotion of coordination of care between BH and PH providers and providers. Aetna facilitates various collaborative committees and workgroups which include health plan staff members as well as PCP and BH providers. These groups review and analyze data on the continuity and coordination of care between BH and PH. Where opportunities exist, these are prioritized, and collaborative actions are implemented. Aetna acts to improve continuity and coordination of care across the health care network.

Based on our efforts to integrate BH and PH, our Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) measure improved from 81.53% in HEDIS 2018 to 83.03% in 2019.

Continuity and coordination of care activities between PH and BH include the following:

- Monitoring data trends for opportunities to improve the exchange of information
- Assessment of the appropriate diagnosis, treatment, and referral of BH disorders commonly seen in primary care
- Assessment of the appropriate uses of psychopharmacological medications
- Assessment of the management of treatment access and follow-up for enrollees with coexisting PH and BH disorders
- Implementation of primary or secondary preventive BH programs

- Assessment of needs of enrollees with severe and persistent mental illness

Table 6.9.1-5 describes examples of our activities to monitor continuity and coordination of care between physical and behavioral health care.

Table 6.9.1-5: Continuity and Coordination Between Physical and Behavioral Healthcare in West Virginia

Continuity and Coordination Between Medical and Behavioral Health Care Activities	Aetna Activity
Exchange of Information between BH and PH providers	Surveys of BH and PH providers regarding satisfaction with information exchanged
Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care	HEDIS Antidepressant Medication Management Effective Acute Phase Treatment Effective Continuation Phase Treatment
Appropriate use of psychotropic medications	HEDIS Follow-Up for Children Prescribed ADHD Medication Initiation Phase Continuation and Maintenance Phase
Management of treatment access and follow-up for members with coexisting physical and behavioral disorders	Aetna NAS Program
Primary or secondary preventive behavioral health care program implementation	Postpartum Depression Screening Program
Special needs of members with severe and persistent mental illness	HEDIS: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Medical Records Review

Aetna requires network providers to maintain an organized, confidential system for documenting and storing our enrollees' medical information. At any time, the CMO, QM/UM Committee, or Aetna Credentialing Committee may request a review of a practitioner or provider's medical records. The Quality Management department is responsible for coordinating the review

process; on an annual basis, we complete a medical record review sample of 70 to 80 charts from 18 sampled providers across West Virginia. If the results of the review indicate the practitioner/provider records do not meet State contract standards, Aetna may require the practitioner/provider to develop and implement a CAP approved by Aetna. Should ongoing delinquencies occur with failure to meet CAP goals, provider repercussions can be up to and including termination from the provider network. Additionally, the Quality Management department is responsible for monitoring trends identified and developing systemic corrective action plans to address or apply applicable follow-up activities. The Aetna CMO and the QM/UM Committee review these reports and submits summary reports to the QMOC and to the board of directors, outlining any systemic issues and remediation efforts.

External Quality Review

Aetna actively participates in an external independent review performed by BMS. Aetna provides BMS with access to site, information, documentation, and data. Aetna and our subcontractor(s) makes available to BMS 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 EQRO, HEDIS, encounter data validation, and other related activities. Aetna submits a CAP, as determined by BMS, and within the timeframes established by the agency to resolve any performance or quality of care deficiencies identified by BMS' ongoing monitoring activities and any independent assessments or evaluations requested by the agency. Aetna obtains advance

As a result of our inter-departmental quality management culture, led and supported by our top leadership, our EQRO scores in West Virginia have excelled over the past 4 years:
- 2015: 100%
- 2016: 100%
- 2017: 99%
- 2018: 100%

written approval from BMS before releasing or sharing data, correspondence and or/ improvements related to the internal QM program with any other external entity.

Correction and Remediation of Significant System Problems

Aetna has written policies and procedures to take remedial action based on our internal surveillance, complaints, or other mechanisms such as notice from BMS, including requiring CAPs within 30 calendar days of the identification of the problem. CAPs are well-defined and include the following:

- Specification of the types of problems requiring remedial/corrective action
- Specification of the person(s) or body responsible for making the final determinations regarding quality problems
- Specific actions to be taken
- Provision of feedback to appropriate health professionals, providers, and staff
- The schedule and accountability for implementing corrective actions
- The approach to modify the corrective action if improvements do not occur
- Procedures for terminating the affiliation with the physician, or other health professional or provider

CAPs are closely monitored by our quality management committees to ensure appropriate changes have been made, including the QMOC, the QM/UM Committee, Delegation Committee, and Compliance Committee. Further follow-up actions are identified and tracked by these committees until the issue is satisfactorily resolved. This information is used in recredentialing, re-contracting, and/or annual performance evaluation. Failure to successfully improve through a CAP could in additional oversight and monitoring, peer-to-peer discussion, financial penalties, suspension of privileges, termination of contract, and other follow-up determined necessary.

Ensuring Appropriate Oversight of Subcontractors

QU006	The Vendor should describe its policies and procedures regarding utilization of reports and data from subcontractors to ensure appropriate oversight and member access, satisfaction, and continuity of care.

Aetna undertakes subcontracts only when doing so adds value for our enrollees. We use well-qualified, experienced subcontractors only when necessary because of our high level of

confidence in the professional team we have assembled and our ability to hire locally to provide services in support of our current West Virginia Medicaid program. When we do need subcontractors with unique expertise and a proven record of accomplishments, we engage them for specific deliverables and services relative to improving outcomes for our enrollees by providing appropriate, coordinated care and services in a financially responsible manner. We require their submission of detailed reports and data to ensure appropriate oversight of member access, satisfaction, and continuity of care. Our current subcontractors (VSP Vision Care, eviCore, and SKYGEN USA) have an established relationship with our health plan and our internal network relations manager, and currently demonstrate sustained quality performance serving our Medicaid enrollees, fulfilling all required quality metrics.

Subcontractor Monitoring and Oversight Activities

Monitoring is performed as follows:

- Monitoring and evaluating delegated functions through at least semiannual reports
- Conducting pre-assessments prior to delegation, with annual desk audits or web conference reviews conducted with a random sampling of files thereafter
- Confirming (no less than annually) that delegated functions/services are carried out consistently and in compliance with both Aetna's and other applicable accredited standards (i.e., NCQA and others as indicated) and the mutually agreed upon delegation agreement
- Performing, at minimum, an annual file review audit, if applicable, to confirm compliance with Aetna and applicable standards
- Monitoring ongoing corrective actions to address identified deficiencies, promote progress, and take necessary action, if improvements do not occur
- Reviewing the delegated organization's program that oversees the delegated functions and its quality program to verify it is in alignment with Aetna's quality improvement processes
- Monitoring the subcontractor downstream provider agreements to ensure they comply with the regulatory requirements of the State contract

Our established policies and procedures for compliance monitoring including oversight of subcontractors as a health plan-wide endeavor; Aetna's management team uses an integrated and collaborative approach that involves each operations area to ensure compliance with the

contract. Every department monitors performance as part of its daily operational routine. Our compliance program includes oversight committees with representation from team members throughout the plan and our participating providers. These committees perform day-to-day oversight activities for internal monitoring of operations, including oversight of subcontractors to assure appropriate member access, satisfaction, and continuity of care.

Aetna performs ongoing monitoring of subcontractor performance, including meeting with subcontractors on a weekly, monthly, or quarterly basis, depending on the subcontractor and the task for which they are responsible. We also perform a comprehensive review at least annually in which we review ongoing performance as well as measure performance efforts that address past concerns identified by the Department. If any deficiencies or areas for improvement are identified, we require the subcontractor to take corrective action. If requested, Aetna provides the Department with a copy of the annual review and any CAPs developed as a result.

National oversight: At the national level, we have a centralized team of delegation oversight experts that manages the oversight process across the Aetna Medicaid organization to make certain that all of our multi-state delegated agreements are represented and that all requirements, such as state- and contract-required elements for each plan and delegate, are in compliance.

Local West Virginia oversight: The Quality Management Oversight Committee (QMOC) has the ultimate authority and responsibility to validate that monitoring requirements are met. The committee meets six times per year and reports to senior leadership. In order to ensure ongoing communication and coordination between the national and local Delegated Vendor Oversight Committees, our West Virginia quality management director participates on the national team monthly and chairs the local committee quarterly, where she shares meeting minutes and

identified issues. The local committee can proactively research issues learned at the national committee via other states that use the same vendors.

In accordance with Aetna's culture of compliance, all team members understand they play a role in subcontractor oversight. Team members from the Network Management, Provider Services, Operations, and Quality Management departments are trained to report subcontractor-related concerns to management. For example, our care coordinators are often the front line in identifying potential problems or issues related to vendors and subcontractors. If an interaction with a member related to a subcontractor raises a red flag or suggests there is a problem, the care coordinator will escalate the issue to management. Issues can often be resolved without further escalation once they are referred to the appropriate department for remediation. Audit reports of delegated activities and corrective action plans, if applicable, are submitted to the appropriate oversight committee (e.g., Quality Management/Utilization Management [QM/UM] and Delegation Oversight Committees) for review and approval and then to the QMOC.

The Medical Management, QM, Provider Services, and if applicable, Care Management and UM departments and their appropriate committees are responsible for implementing the oversight process and maintaining monitoring activities, including monitoring the delegate's provisions to safeguard members' protected health information, as applicable. Should deficiencies be identified, Aetna works with the delegated organization to set priorities and develop a CAP. We retain the right to revoke the delegation agreement for noncompliance or if CAPs are not sustained.

Taking Action Against Providers Demonstrating Unacceptable Performance

QM and Provider Services staff work together to monitor network provider performance. QM staff assists Provider Services staff in developing measurable objectives to evaluate provider performance; analyze data collected in the monitoring process; and prepare information for the

QMOC. If the reported data indicates the need for an action plan or additional studies, QM will assist in developing tools and reporting results and outcomes to the QMOC and to the Department, as appropriate. The Aetna QM/UM Committee conducts peer review and investigates quality of care or service and enrollee safety issues, makes recommendations to the chief medical officer (CMO)/medical director, and requests follow-up by the Aetna Credentialing and Performance Committee (CPC), if appropriate. The Aetna CPC is responsible for conducting professional review activities involving the practitioners whose professional competence or conduct adversely affects or could adversely affect the health or welfare of enrollees. The range of actions available to the QM/UM Committee and/or the CPC includes practitioner education, requirement of a corrective action plan, or termination of the practitioner contract, if indicated. Actions taken by the QM/UM Committee or the CPC are reported to QMOC and the Department, as appropriate.

The local West Virginia QM team actively works with network practitioners across the state when unacceptable performance patterns are identified. For example, during the annual medical record documentation audit, individual practitioner performance is compared to the established goals. Any providers who score below the goal receive individualized feedback on areas not meeting the goal. The QM team shares these results with the Provider Services team, who will meet directly with the provider to review the results and offer suggestions for improvement. Those providers who do not adequately meet the medical record documentation goals are automatically included in the next year's audit in order to review a sample of medical records again and assess for improvement.

[QU006] Utilization of Reports and Data from Subcontractors to Ensure Appropriate Oversight and Member Access, Satisfaction, and Continuity of Care

Although we may delegate the authority to perform functions in support of the West Virginia Medicaid managed care program, **we do not delegate accountability for the quality of care or services the subcontractor provides**. Our QAPI program follows established policies and procedures to manage the delegation of responsibility for any delegated program function.

Aetna's local Delegation Oversight Committee requires all subcontractors to report various measures and trends to the committee to ensure comprehensive oversight of its subcontractors, including member access, satisfaction, and continuity of care including the following:

- **Customer service call data:** Tracked monthly to ensure that members have access for customer service needs
- **Claims data:** Monthly data on claims payment timeliness and accuracy is reported to the Delegated Oversight Committee on a quarterly basis
- **Network adequacy:** Reporting on requests for out-of-network services, which is a key indicator of the subcontractor's ability to adequately provide needed services.
- **UM reviews, including clinical reviews, prior authorization, and retroactive authorization reviews:** Monthly data is reported on a quarterly basis to the local Delegation Oversight Committee by each subcontractor in order to monitor utilization practice patterns. In addition to the monthly/quarterly monitoring noted above, our national Delegation Management team conducts an annual oversight audit of each subcontractor to evaluate subcontractors' compliance with standards and criteria. We build on our company-wide subcontractor monitoring processes to hold ourselves accountable for the performance of all our subcontractors, and we understand that no subcontract relieves us from any obligation or liability arising from our contract with the State.

Using Subcontractor Data to Monitor Outcomes Related to Member Access

Aetna monitors subcontractors' accessibility and availability on an ongoing basis to help ensure established standards for reasonable geographical location, ratio of subcontractors to members, hours of operation, appointment availability, and coverage for emergency care and after-hours services, as applicable. In order to monitor subcontractor outcomes related to access to care, we use encounter data submitted by our vendors on a weekly and monthly basis. In addition, we

use data received through our provider appointment survey to monitor appointment availability and subcontractor compliance.

Subcontractors identified as not meeting the standards are discussed, and we work with the identified subcontractor to get the necessary actions required implemented to meet access to care requirements. If access to care issues arise, it would result in contract remediation up to contract termination. We hold quarterly oversight JOC meetings with our major subcontractors to ensure effective, ongoing communication. The West Virginia Aetna leadership team (chief executive officer [CEO], CMO, and department directors) attends all JOC meetings where the subcontractor is expected to present on their current issues and successes, including membership, customer service, claims processing, provider credentialing, appeals and complaints, utilization review, reporting, provider relations, and trends.

Using Subcontractor Data to Monitor Outcomes Related to Member Satisfaction

All subcontractors are required to monitor member satisfaction as well as dissatisfaction and to send member complaints to Aetna for resolution. Each case is discussed individually in JOC meetings. Increases and trends in complaints are brought to the Service Improvement Committee (SIC) for discussion and possible corrective action. Our subcontractors are open to collaborative projects to better the health outcomes of our members. For example, SKYGEN USA helped to identify dental providers in certain geographic locations who might be willing to collaborate with Aetna to host a dental well-visit clinic. VSP collaborates with Aetna by sending reminders to members with diabetes to encourage a diabetic eye exam. These efforts contribute to increased member satisfaction with accessibility of services.

Using Subcontractor Data to Monitor Outcomes Related to Continuity of Care

Aetna recognizes the importance of maintaining continuity of care and service whenever a member's care setting or practitioner/provider changes. Aetna integrates processes to guard against interruptions in care. We track issues related to continuity of care with our subcontractors through out-of-network referrals in weekly reports to ensure our members have access to the services they need; we create single case agreements as needed. In addition, we receive approved and denied authorizations, which are then reviewed by Prior Authorization staff for appropriateness. On a quarterly basis, the Delegated Oversight Committee will review out-of-network referrals for continuity of care and transitions of care and related concerns, and if issues are identified, the subcontractor may be put on a CAP. For our dental subcontractors, we receive a quarterly report on terminated providers and dates of member outreach. This data is reviewed during the JOC meetings. Issues identified affecting the continuity of care for our dental subcontractors are addressed through an action plan implemented at that time. Our provider relations representatives meet with subcontractors on a monthly basis to proactively identify and resolve issues to avoid necessitating a CAP.

Member Satisfaction

QU007	The Vendor should describe how they will administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.
QU008	The Vendor should describe its process to administer and utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results to identify and investigate areas of member dissatisfaction, outline action steps to follow up on survey findings, and disseminate findings with providers.

Aetna listens to our members and takes their satisfaction very seriously. We believe that every contact with our members is an opportunity for a positive interaction and to reinforce our commitment to their health outcomes and satisfaction with our services. We are committed to continually improving our Consumer Assessment of Healthcare Providers and Systems

(CAHPS) scores on an ongoing basis. We incorporate the results of the CAHPS survey and member satisfaction information into **our member-devoted quality management program** to identify and prioritize opportunities for improvement in the care provided to our members. **Table 6.9.1-6** illustrates the different settings and processes facilitated by our quality program to collect actionable member satisfaction feedback.

Aetna gathers member satisfaction survey results at all wellness events. In 2019, 100% of members reported they strongly agree/agree with the metrics of "I am satisfied with today's wellness event" and "I would attend another Aetna Better Health of West Virginia wellness event."

Table 6.9.1-6: Data Collection Methodologies for West Virginia Member Satisfaction

Data Collection Methodology	Description
Member Satisfaction Surveys	We complete the NCQA Adult and Child CAHPS surveys annually, as well as a Behavioral Health Member Satisfaction Survey, both adult and child versions, to evaluate member experiences for BH care services. We will also be utilizing the CAHPS survey for children with chronic conditions for our enrollees in the foster care system. Additionally, we provide a satisfaction survey to participants of the wellness events, including items such as convenience of the time and place and if the individual would attend another event in the future.
Focus Groups	We will conduct four focus groups throughout the year with members across the state as an opportunity to gather feedback on barriers to care and where services are being most impactful, so programmatic changes can be made to improve the overall health of the program.
Member Advisory Committee (MAC)	The MAC provides feedback to Aetna regarding strategies for improving member care and services including health education and other member materials. Chaired by the manager of Member Services, the membership includes Aetna staff and a maximum of 15 member representatives from across all West Virginia regions. We hold MAC meetings quarterly in various locations across the State and provide support, as necessary.
Automated Satisfaction Survey	Aetna offers a short, automated post-call satisfaction survey at the completion of every member call with our Member Services department. Aetna uses the data obtained for training and coaching purposes.

Data Collection Methodology	Description
Member Inquiries, Complaints, and Appeals	Our member services representatives make every effort to resolve the member's complaint at the point of first contact and document the status and final disposition of the issue. Members can call the member services hotline anytime, and a representative can assist in documenting a member's concern, assuring Quality Management and Grievance and Appeals department involvement and resolution. Aetna uses information from complaint and appeals data for trending and analysis that may be correlated with member survey data in the assessment of opportunities for improvement and for the development of action plans for both physical health (PH) and behavioral health (BH).
Potential Quality-of-Care (PQOC) Concerns	Aetna documents, addresses, and resolves PQOC (and service) concerns and uses them to determine provider-specific or systems issues that need to be addressed.

[QU007] Administration of the CAHPS Survey

Aetna uses the Center for the Study of Services (CSS), an NCQA-certified survey vendor to conduct our CAHPS surveys. In 2019, the CAHPS 5.0H Adult Medicaid and Child Medicaid Member Satisfaction Surveys were administered in accordance with the NCQA sampling and data collection protocols between February 16th and May 15th, 2019 to reflect January to December 2018 member satisfaction. Following the NCQA sampling protocol, CSS selected a random sample from the complete list of eligible members provided by Aetna. Following NCQA sampling protocol, CSS employed a systematic sampling process from the complete list of eligible members provided by Aetna.

The two Adult and Child CAHPS surveys included questions related to eleven key measures which include global ratings, composites, and additional content areas. The global measures reflect overall satisfaction with the West Virginia health plan, health care, personal doctors, and

specialists. The composite measures and additional content areas are sets of questions grouped together to address different aspects of care (e.g., Getting Needed Care or Getting Care Quickly).

CAHPS Children with Chronic Conditions Survey

Aetna is in the process of implementing the CAHPS survey item set for children with chronic conditions to identify barriers to care for individuals with special health care needs for our children and youth in the foster care system and individuals receiving adoption assistance. This version of the CAHPS survey expands beyond the standard CAHPS child survey to assess areas related to health providers contacting school or daycare center about the child's health, special medical equipment, special therapy such as physical/occupational/speech therapy, and offerings of counseling for emotional, developmental, or behavioral problems. Understanding issues from this survey may bring to light opportunities to support children who are moving between the Medicaid/WVCHIP and the foster care programs.

CAHPS surveys include questions related to a range of health care services at multiple levels of the delivery system as depicted in **Table 6.9.1-7.** The survey includes the member's rating of their personal doctor, specialist seen most often, all health care received, and health plan overall. The qualitative analysis performed of Aetna's West Virginia Child and Adult enrollees showed members were satisfied with their ability to get needed care, tests, or treatment.

Table 6.9.1-7: Aetna 2018 and 2019 Child and Adult CAHPS Results Meeting the 75th and 90th Percentiles

CAHPS Measure	2018 Rate and Percentile	2019 Rate and Percentile
Child		
Getting Care Quickly Composite	94.83%/75th	95.92%/90th
Getting Needed Care Composite	89.30%/75th	93.02%/90th
How often did you get an appointment for your child to see a specialist as soon as you needed?	85.85%/75th	88.10%/90th
How often was it easy to get the care, tests, or treatment your child needed?	92.75%/75th	97.95%/90th

CAHPS Measure	2018 Rate and Percentile	2019 Rate and Percentile
When you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?	92.55%/75th	93.68%/90th
When your child needed care right away, how often did your child get care as soon as he or she needed?	97.11%/90th	98.16%/90th
Adult		
Getting Care Quickly Composite Measure	85.14%/75th	86.74%/75th
Coordination of Care	86.47%/75th	86.49%/75th

[QU008] Utilizing the CAHPS Survey Results

The CAHPS survey measures how well Aetna is meeting members' expectations, which we use to identify and investigate areas of member dissatisfaction in order to outline action steps to follow-up on findings. Both NCQA Quality Compass National Medicaid Averages and NCQA percentiles are used to gauge plan performance. Member satisfaction percentage results are used to evaluate Aetna member satisfaction trends over time with improvement goals set based on our scores. We drill down on summary rates to identify specific barriers and develop an action plan to improve the member experience. The action plan includes implementation steps and a timeline for completion. Based on this analysis, the CAHPS review team reviews the key measures, drivers, and data to identify barriers, discuss opportunities for improvement, and prioritize actions.

Identifying and Investigating Areas of Member Dissatisfaction

NCQA Quality Compass National Medicaid percentiles were used to show Aetna West Virginia performance (ranking) relative to other national Medicaid plans that reported to NCQA Quality Compass and to set goals for the following year. Key survey measures are evaluated in order to

gauge Aetna's performance and set goals for the subsequent year. This process includes evaluation of the following:

- Aetna's current-year results consisting of global ratings and composite scores
- Changes in scores from the previous years
- Comparisons to relevant national benchmarks
- Measures identified by CSS to be key drivers to member satisfaction that contribute to the overall rating of the plan

Results of members' ratings of and experiences with the care they receive are used to identify potential improvement opportunities and develop action plans that address these areas. A comprehensive analysis of CAHPs survey results is performed by multidisciplinary workgroups that include representation from the following:

- Member Services
- Provider Services
- Grievance and Appeals
- Quality Management
- Network Management
- Senior Management team, including the CEO, CMO, and department directors

The workgroups assess member satisfaction with health care and discuss key measures and drivers of the member experience. Through our CQI/Plan-Do-Study-Act (PDSA) process, the workgroups identify opportunities for improvement and recommend action plans to be presented during regularly scheduled committee meetings. The initial analysis of CAHPS results and corrective action plans are developed in an ad hoc CAHPS workgroup, then presented to the QM/UM Committee and QMOC in the fall of each year. In the spring, we do an overall member satisfaction analysis including complaint data that goes to SIC and QMOC. The purpose of this analysis is the following:

- Assess member satisfaction with services and quality of care provided by Aetna
- Document health plan performance
- Develop actions to improve the member experience and quality of care with the health plan
- Compare performance against other West Virginia Medicaid plans and with other states' Medicaid plans for ongoing process improvements

Provider Satisfaction

We recognize the direct correlation between provider satisfaction and member satisfaction and leverage this linkage to identify barriers and improve member experience. The Practitioner Satisfaction Survey assesses practitioner satisfaction with services that are important to Aetna network of practitioners and overall satisfaction with the health plan. Annually, Aetna administers the survey to a sampling of PCPs, specialists, and BH providers. Information obtained from the survey allows Aetna to measure how well the health plan is meeting providers' expectations and needs. Provider surveys address satisfaction with Aetna's utilization management procedures (prior authorization, concurrent review) claims processing, and Aetna's response to inquiries. Aetna reports the analysis of results and applicable follow-up actions developed to address unfavorable results to the Service Improvement Committee and QMOC.

From 2018 to 2019, Aetna significantly improved the Overall Satisfaction with Aetna Better Health of West Virginia score from 69.7% to 73.5%—6.9 percentage points above the Medicaid average of 66.6%

We work closely with our subcontractors and providers to assist them in their performance improvement initiatives; we go beyond simply providing them actionable reports on a regular basis by meeting with them onsite to discuss their rates, trends, gaps in care, and any other barriers they may be experiencing. Every provider has an assigned provider relations representative who meets with them regularly to provide education and resolve barriers. We provide HEDIS education, help them to close enrollee gaps in care, and assist them with improved documentation and coding. As depicted in **Figure 6.9.1-5,** the Quality Management department works closely with the Provider Relations department to acknowledge and reward providers who excel in HEDIS performance, actively collaborating with us and providing quality care to our members.

Aetna uses the results of the Provider Satisfaction Survey as part of our CQI process. As one example, we used comments and scores from the survey as the catalyst for improving our provider orientation process. In 2017, the West Virginia provider satisfaction score was 9.5 percent at above average or well above average. We created a provider orientation tool kit, rolled out new provider webinars, and improved the quality of our provider bulletins and announcements. In 2018, the score was 19 percent at above average or well above average. We continued to improve the hand off between contracting/credentialing to the Provider Relations staff, established existing provider update webinars, and reformatted the annual provider workshops. In 2019, the score went up to 25.8 percent above average or well above average.



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Figure 6.9.1-5: Aetna Provider Award
On November 13, 2019, Aetna Quality Management and Provider Relations staff met with Cabin Creek Health System to celebrate their Quality All-Star Award and present them with a commemorative trophy.

Outlining Action Steps to Follow Up on Survey Findings

Aetna follows the CQI PDSA process to prioritize identified issues, address concerns, implement interventions, and reassess issues to determine change in satisfaction. The formal process includes member and practitioner/provider communications and reporting to QMUM, QMOC, and the board of directors documented in committee minutes.

As depicted in **Figure 6.9.1-6,** Aetna staff work to reduce provider burden and increase satisfaction through face-to-face visits, phone calls, webinars, web portal capabilities, gaps-in-care reports, and pay-for-quality programs.

Incorporating CAHPS Survey Results into Quality Management Program and Disseminating Findings

We provide the survey results to both West Virginia members and providers to improve the quality of care and service provided to members. We analyze member feedback to gain insight into the relationship of the health plan with members and to identify opportunities for improvement. In addition to individualized and formalized annual CAHPS improvement plans, we incorporate member satisfaction data from the adult and child CAHPS into the full QAPI program, weaving member satisfaction efforts throughout every department.


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Figure 6.9.1-6 Aetna Staff Meet with Roane General Hospital
Aetna Quality Management staff met with Roane General Hospital staff to provide support in coding, gaps in care, collaborative opportunities, provider and member rosters, chart review, and incentives.

We gather indicators of member and provider satisfaction through on-the-spot surveys following Member Services and Care Management calls, text messaging member surveys, and provider face-to-face conversations. For example, CAHPS results are used to evaluate key staff performance and to identify gaps in service that are causing dissatisfaction so that action can be taken to improve member experiences throughout the year.

Aetna has a cross-departmental workgroup that develops and implements a CAHPS improvement plan monitored by the Service Improvement Committee. All departments play a role in member satisfaction including but not limited to Member Services, Appeals, Grievances, and Utilization Management. Our current action plan includes strategies to improve rates prioritized by key measures that affect the member's health care and engagement with

Aetna. Examples of actions include the following, which we expect to improve member satisfaction with both Aetna West Virginia's providers and Aetna West Virginia health plan:

- Member Services team directly outreaching to members
- Soft skills training to improve satisfaction with customer service
- Enhancements to interactive voice recognition to allow for scheduling of appointment assistance and easier navigation for contacting care management
- Network adequacy meetings
- Provider recruitment

Based on the findings of our CAHPS barriers analysis, we compile a CAHPS Action Plan for improvement as depicted in **Table 6.9.1-8.**

Table 6.9.1-8: West Virginia CAHPS Action Plan

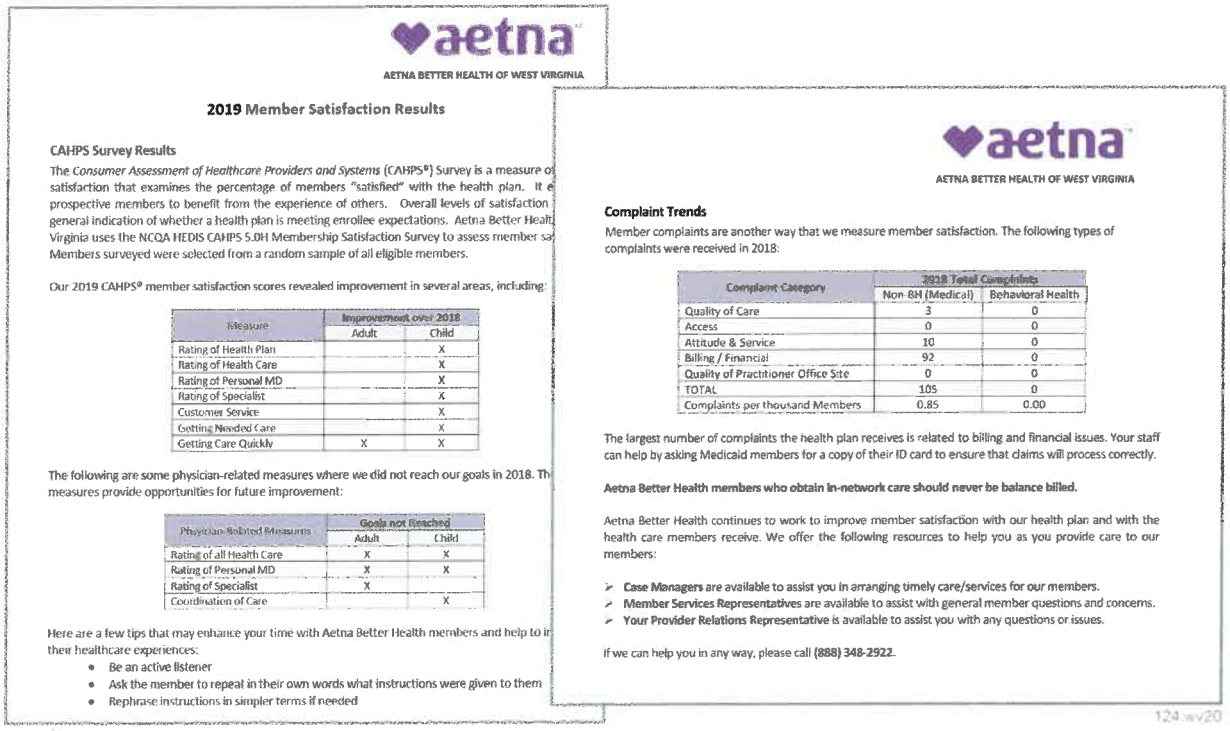
Measure	Interventions	Intervention Details
Rating of All Health Care	• Assist members in getting needed care and maintaining health and wellness • Explore possibility of giving member service representatives direct access to gaps in care reports • Promote telehealth services • Establish process for Member Services to assist members in getting documentation for guardianship • Work to clarify and simplify urine drug screening coverage limitations • Trauma-informed care (TIC) health plan project • Implement contract with new gift card vendor	• Implement peer support specialist program; use community health workers; increase number of embedded care managers (CMs); hold wellness clinics; promote Cub Club Program • Explore the possibility of having smart user view interface with our care management system to give Member Services access to gaps in care reports • Educate providers about telehealth in portal; collaborate with State on telehealth; work with West Virginia University (WVU) to offer telehealth to children with cancer; collaborate with Anytime Pediatrics to expand telehealth services in the state; CM team to educate members; Aetna provided grant to WVU to offer BH telehealth services from psychiatrists to PCPs • Establish process/desktop and education for Member Services to assist members in getting proper documentation for guardianship • Educate providers on how to apportion substance use disorder (SUD) service limits • Provide TIC training and Mental Health First Aid training to all member-facing staff; provide TIC training to provider offices; hold monthly TIC core implementation team meetings

Measure	Interventions	Intervention Details
Rating of Personal Doctor	• Make improvements to claims payment process • Multi-department effort to educate members about importance of seeing PCP and getting needed care • Educate PCPs on use of member panel information, including gaps in care reports • Implement process to reduce inaccuracies on gaps in care reports • Work with PCP practices to maximize reimbursement for providing member care • TIC health plan project	• Work to resolve issues on weekly calls; specially trained unit within Provider Services call center that can address Provider Relations (PR) issues in real-time. • Member Services to verify PCP and educate members on importance of seeing PCP and use gaps in care information to encourage preventive health visits; Care Management will verify PCP and focus on gaps in care • Provider education on importance of accessing and using member roster; target high-volume PCP offices for in-office education by PR representative • HEDIS team to compile database when provider reports errors and send report to PR; PR to review reports from HEDIS team and follow up to make corrections • Work to increase value-based arrangements with PCP practices and help them be successful by operationalizing value-based arrangements
Rating of Health Plan	• Promote the MAC and recruit members • Evaluate welcome call and health risk questionnaire (HRQ) content and reports to identify areas for improvement • Focus on member satisfaction on an ongoing basis • TIC health plan project • Adjust member newsletter schedules to coincide with CAHPS results and annual contract release	• Promote MAC at Ted E. Bear, M.D[SM]. fair and food drives; include CM; have CM invite members; invite parents who attend appeals in person; increase incentive; promote MAC in newsletter and web • Explore welcome call and HRQ call content and reports; consider using auto-dialer for non-interactive member calls; explore use of welcome texts • Member services net promoter score initiative; start reporting a summary of post-call survey results quarterly to SIC; implement Member Services Quality Stars Program

As depicted in **Figure 6.9.1-7** we disseminate a summary of CAHPS and member satisfaction performance annually to providers through provider alerts that are sent via fax/email and mail,

as well as posted on our website under the Provider News tab at

https://www.aetnabetterhealth.com/westvirginia/providers/library.



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2019 Member Satisfaction Results

CAHPS Survey Results

The *Consumer Assessment of Healthcare Providers and Systems* (CAHPS®) Survey is a measure of satisfaction that examines the percentage of members "satisfied" with the health plan. It e prospective members to benefit from the experience of others. Overall levels of satisfaction general indication of whether a health plan is meeting enrollee expectations. Aetna Better Healt Virginia uses the NCQA HEDIS CAHPS 5.0H Membership Satisfaction Survey to assess member sa Members surveyed were selected from a random sample of all eligible members.

Our 2019 CAHPS® member satisfaction scores revealed improvement in several areas, including:

Measure	Improvement over 2018	
	Adult	Child
Rating of Health Plan		X
Rating of Health Care		X
Rating of Personal MD		X
Rating of Specialist		X
Customer Service		X
Getting Needed Care		X
Getting Care Quickly	X	X

The following are some physician-related measures where we did not reach our goals in 2018. Th measures provide opportunities for future improvement:

Physician-Related Measures	Goals not Reached	
	Adult	Child
Rating of all Health Care	X	X
Rating of Personal MD	X	X
Rating of Specialist	X	
Coordination of Care		X

Here are a few tips that may enhance your time with Aetna Better Health members and help to ir their healthcare experiences:

- Be an active listener
- Ask the member to repeat in their own words what instructions were given to them
- Rephrase instructions in simpler terms if needed

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Complaint Trends

Member complaints are another way that we measure member satisfaction. The following types of complaints were received in 2018:

Complaint Category	2018 Total Complaints	
	Non-BH (Medical)	Behavioral Health
Quality of Care	3	0
Access	0	0
Attitude & Service	10	0
Billing / Financial	92	0
Quality of Practitioner Office Site	0	0
TOTAL	105	0
Complaints per thousand Members	0.85	0.00

The largest number of complaints the health plan receives is related to billing and financial issues. Your staff can help by asking Medicaid members for a copy of their ID card to ensure that claims will process correctly.

Aetna Better Health members who obtain in-network care should never be balance billed.

Aetna Better Health continues to work to improve member satisfaction with our health plan and with the health care members receive. We offer the following resources to help you as you provide care to our members:

- **Case Managers** are available to assist you in arranging timely care/services for our members.
- **Member Services Representatives** are available to assist with general member questions and concerns.
- **Your Provider Relations Representative** is available to assist you with any questions or issues.

If we can help you in any way, please call **(888) 348-2922**.

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Figure 6.9.1-7: Dissemination of CAHPS and Member Satisfaction Information
Aetna keeps providers notified of CAHPs, member satisfaction performance, and other important information through actionable summaries

Innovative Strategies for Improving Engagement and Member Satisfaction

In addition to the ongoing work described in **Table 6.9.1-8**, a key strategy for Aetna to improve rates for member satisfaction will be a **mid-year member experience assessment outreach attempt** to **100 percent of our membership** beginning in 2020 to 2021. This assessment will ask members or their parents/guardians about their experiences and satisfaction with their health care and accessibility, specialists, and PCPs, as well as tobacco use and other factors affecting their health. Responses will be examined based upon ZIP code and provider/group level; Quality Management staff will prioritize contacting providers with below average ratings to review findings and supply technical assistance such as scheduling, front-office staff interaction

with members, and health literacy. Responses will be utilized as part of the PDSA process for member initiatives.

Health Equity and Social Determinants of Health Training

QU005	The Vendor should describe its approach to having staff and providers receive initial and ongoing training on health equity and Social Determinants of Health (SDOH).

Aetna ensures that all enrollees, providers, and staff are treated with respect concerning their culture, values, race, age, sexual orientation, ethnic background religion, and disability status, including individuals with BH and substance use challenges. **We are West Virginians,** which empowers us to make a significant impact in communities across our State to address social determinants of health (SDOH) barriers for our enrollees. Because of our focus on SDOH and their impact on health care access and quality of life, Aetna includes attention to socioeconomic status and access to housing, nutrition, education, and employment. With our CCT model and focus on SDOH, we believe we can help improve health and social outcomes for all the populations we serve.

Initial and Ongoing Training on Health Equity and Social Determinants of Health

West Virginians enrolled in Medicaid and West Virginia Child Health Insurance Program (WVCHIP) may face vulnerabilities in their physical, social, and mental health requiring seamless access to services. Our local, regionally based CCTs understand the health disparities, risk to health equity, and SDOH barriers for West Virginians, especially in the communities where they live and work. Aetna also recognizes the potential overlap with our children in the foster care population and will support them to resolve rising risk indicators; we add immediate supports to child and families upon early identification of SDOH and other factors.

Aetna's regionalized approach is driven by our recognition of local disparities, gaps in resources, and our commitment to promoting health equity for all enrollees. We coordinate a comprehensive array of services across life domains that address physical, social, and BH needs, guided by an individualized, integrated service plan.

In order to meet plan objectives, it is necessary to understand the needs of Aetna enrollees in each region of West Virginia. Aetna maintains cultural competency initiatives to address specific cultural/language needs that might challenge an enrollee's ability to access care or understand healthy practices that lead to optimum health outcomes. Clinical and nonclinical internal staff are subject to Aetna's cultural competency measures and training. Specific activities include the following:

- Training staff members about the need for understanding of and respect for cultural differences when interacting with enrollees and developing services that better meet the needs of minority populations
- Educating providers and practitioners about cultural competency and health care equity
- Providing enrollees and network practitioners with access to interpretive and sign language services for Aetna enrollees
- Promoting development of qualified, diverse, and culturally competent employees
- Assessing applicable feedback from enrollees about programs, quality initiatives, enrollee materials, and other education and outreach tools

Staff Training

Staff training begins upon hire and continues regularly throughout employment. In West Virginia, ongoing trainings include but are not limited to health equity, cultural competency, SDOH, trauma-informed care, motivational interviewing, Mental Health First Aid, gaps in care, assessment and treatment of SUD behavioral health services, addressing obesity in individuals with mental illness, national

The West Virginia Aetna team was one of the first plans in the country trained in advanced coursework on trauma-informed care, Mental Health First Aid, motivational interviewing, and the fundamentals of development, including age-appropriate and stress-related behaviors, adolescent substance use, and permanency training.

diabetes prevention program, enrollee rights, utilization management clinical guidelines and medical necessity, confidentiality, service excellence, and information systems training as it relates to the documentation, storage, and sharing of screenings, assessments, and treatment plans with members of the care team and in electronic platforms. Staff receive ongoing monthly and quarterly training through online modules and are encouraged to attend external conferences as required for licensure. Specifically, health equity and SDOH topics are covered in our Cultural Competency 101, trauma-informed care training, system of care training, care management training, as well as within our quarterly cultural conversation forum.

As a trauma-informed care organization, our Care Coordination, Member Services, and Community Outreach staff receive comprehensive and ongoing training established in partnership with the National Council for Behavioral Health. We had a kickoff event with the National Council specific to West Virginia in January 2019, including a day-long training event for all staff. In total, we have trained approximately 2,500 Medicaid staff in foundational trauma training since 2018. In West Virginia specifically, 93 percent of staff in have completed the National Council's on-site TIC training, and our goal is to have 100 percent trained by the fourth quarter of 2020 (including our new foster care staff). We have future trainings scheduled for staff and providers with the National Council for Behavioral Health onsite in February 2020. We will be providing advanced training for the staff and then two days of provider training at two sites.

Provider Training

Health equity and SDOH topics are covered in the new provider orientation within 30 days of the provider joining the network as well as annually. We supplement these formal trainings with educational information dissemination throughout the year on topics critical to our populations; as one example, in 2018, Aetna created a white paper for our providers describing

our initiatives to combat the opioid crisis, including prevention, intervention, and support activities:

- **Prevention:** Outreach to high-volume prescribers, Prescriber Drug Monitoring Program, safe storage of opioids and quantity limitations, member outreach and education, reduction in opioid use via alternative therapies, collaboration with leaders in opioid reduction, and predictive analytics and evidenced-based practices
- **Intervention:** Medication-assisted treatment (MAT), Screening, Brief, Intervention and Referral to Treatment, naloxone administration without prior authorization, pharmacy reports inclusive of risk, and pharmacy restrictions for high-risk individuals
- **Support:** Member outreach and education on MAT, employee training and education on opioids, neonatal abstinence syndrome prevention program, opioid-specific care management, care management outreach and education to members, provider directory inclusive of substance abuse providers, and promotion of opioid interventions in health plans

Our white paper also included our next steps to keep providers apprised of ongoing efforts to fight the opioid crisis, including supporting the development of standardized solutions and interventions for opioid interventions, increasing network adequacy of MAT providers, and coordinating and increasing access to peer-to-peer supports. We have also created a provider toolkit available through the provider portal. Some of the training topics include the following:

- Defining trauma
- Prevalence and impact of trauma and adverse childhood experiences
- Building resiliency and hope for recovery in the face of trauma and self-care
- Introducing trauma-informed care
- The importance of trauma-informed care for the populations served by the Aetna Medicaid organization
- Four assumptions of trauma-informed care
- Six principles of trauma-informed care

As we continue our partnership with the Department and our providers, we will look to share new service approaches and promising evidence-based practices for the MHT, WVHB, and WVCHIP program gathered from other providers and our experiences. We will also develop or enhance trainings based on

Aetna's regional provider forums have gained a reputation for being responsive and helpful to West Virginia providers, as evidenced by the 65% increase in participation from 2018 to 2019.

provider feedback and/or Aetna-identified trending provider issues or process pain points identified in feedback from meetings and satisfaction surveys.

Aetna is the only West Virginia managed care organization that conducts provider forums throughout the State. We understand that providers are our most valuable service delivery assets. Our job is to empower our providers through education, assistance, and the resources needed to achieve quality enrollee engagement and health outcomes as the key to connecting members with services to address social determinants of health. Our Provider Relations staff directly contact new providers either in person or by phone to begin establishing a relationship, to review key information, and to respond to any provider questions or concerns. As a part of the implementation process, we will offer our current providers orientation training on West Virginia MHP, MHT, WVHB, and WVCHIP, as well as training on requirements for providing health care services including addressing SDOHs and behavioral health care services to West Virginia enrollees.

Meeting the Needs of Individuals with Special Health Care Need and All Populations

QU003	The Vendor should describe how they will utilize data to identify barriers to care for individuals with special health care needs, and develop policies and procedures for methodologies for collecting and analyzing quality measures for different populations.

Aetna's integrated system of care includes all health care and related services and supports necessary for individuals with special health care needs and all populations to achieve improved health outcomes.

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

[QU003] Using Data to Identify Barriers to Care for Individuals with Special Health Care Needs

Aetna identifies individuals with special health care needs/individuals with complex or serious medical conditions at enrollment and throughout their course of treatment. Upon receipt of a referral or enrollee self-referral for care management, or notification of enrollment of any new enrollee, Aetna begins the initial care management screening process for all West Virginia enrollees. Aetna's automated outbound screening process is our first attempt to complete the health risk assessment (HRA) and health care equity contact event (HCE), which contains 11 SDOH questions with all enrollees and their family/guardian, if applicable. The HRA and HCE screening process allows for initial and immediate stratification to either Tier 1 population health care coordination or to an additional assessment which determines if Tier 2 (supportive) or Tier 3 (intensive) care coordination is appropriate to meet our enrollee's needs. Enrollees that are assigned to population health care coordination (Tier 1) receive educational mailings. All enrollees providing positive responses to any screening question on the HRA and HCE, who may have multiple chronic conditions, SDOH barriers, or other special health care needs will receive further assessment and stratification into the appropriate care coordination level (2 or 3). Immediately following completion of the HRA and HCE, these enrollees will be warm transferred to a care management associate for immediate assessment for enrollment into either Tier 3 or Tier 2 care management.

Aetna outreaches to all new members to complete a health risk assessment, which contains 11 social determinant of health questions, including the domains of transportation, food, utilities, housing, childcare, safety, loneliness, stress, and employment.

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

Children with special health care needs (CSHCN) are identified one of three ways: through the enrollment file sent by the State, internally through claims data/medical management identification, or via our health risk assessment conducted upon initial enrollment. Through our claims data, we identify enrollees that may fall into this category through high utilization and other applicable factors. For children identified with special health care needs, a care coordinator is assigned to assist and support the individual and their family in addressing potential barriers to care.

Aetna has experience in West Virginia managing complex care management programs that proactively identifies enrollees for whom intensive management goals would include improving quality of care and assisting CSHCN to reach their optimum level of wellness.

Membership data for the past three-year period shows a year-over-year increase in the number of children identified with special health care needs. Drill-down of this population revealed the highest number reside in Kanawha, Cabell, and Wood counties. CCTs covering those counties can pinpoint resources available to meet various health and wellness needs. CCT enrollees are also able to conduct face-to-face visits with these children to facilitate care management and address barriers in a timely manner.

Aetna uses Quest Analytics geographical map reporting to identify specific areas or regions that may lack an adequate network of providers trained to work with the special health care needs population. These reports assist in targeted outreach to potential providers and help to develop a network of providers for this specialized population. In addition, we use information gleaned from enrollee input (such as member surveys, focus groups, and our MAC) to assist in identifying any potential barriers that individuals with special health care needs may experience.

Aetna engages in an accessibility analysis for both PH and BH providers. This activity is used to monitor, evaluate, and manage the appointment accessibility of participating practitioners and

enrollees' access to care utilizing the established Aetna standards. The tools used to monitor accessibility include the **CAHPS member satisfaction survey, the annual BH survey, the practitioner appointment accessibility fax survey, member complaints** related to accessibility of practitioners/providers, and **office site visits** conducted during the credentialing process. Aetna will expand the use of these surveys to collect data to identify access to care barriers for individuals with special health care needs.

Aetna's network manager is responsible for identifying network gaps and opportunities for improving and monitoring to make sure identified needs are promptly acted upon. In instances where enrollees are not able to make appointments with the appropriate provider, CCTs and member services representatives will step in, facilitate the request, and even make the appointment if necessary. If a provider is attempting to assist an enrollee with getting an appointment with another provider, Provider Services staff will assist in obtaining the appointment so that the enrollee can receive the care they need in a timely manner. If Aetna is unable to provide necessary medical services covered under the contract within the network of contracted practitioners and providers, we will coordinate these services adequately and in a timely manner with out-of-network practitioners/providers, for as long as we are unable to provide the services in network.

Aetna will work with out-of-network providers to bring them into the network when possible. We establish single case agreements for the current services provided to our members to facilitate continuity of care. The single case agreement requires the provider to treat our members with the same degree of care and skill they provide to patients who are not Medicaid members. If the provider declines to contract with Aetna, the Provider Relations team will identify opportunities to

fill the possible service gap via recruitment, telemedicine options, or identifying a vendor. Aetna supports the family with transportation and room and board for out-of-network services that are out-of-state or that a member cannot access without additional support.

Methodologies for Collecting and Analyzing Quality Measures for Different Populations

Aetna's established policies and procedures include methodologies for collecting and analyzing quality measures for different populations; our Medical Management staff performs an annual population assessment to monitor West Virginia population changes, geographic distribution, language preferences, cultural diversity trends, and changes in rate-group and age distribution within our membership. Data is used to ensure that West Virginia enrollee needs such as practitioner and provider accessibility and availability, translation services, ability to provide services for enrollees with multiple chronic conditions or severe injuries, and continuity and coordination of care continue to be met at the highest levels. Assessment of social determinants of health is a key component of this assessment of our enrollee characteristics and needs.

In addition to collection of HEDIS measures and Aetna staff input, additional methodologies for collecting and analyzing quality measures for different populations includes the following:

- Opioid dashboard
- Member Advisory Committee and focus groups
- Member satisfaction survey
- Review of utilization data
- Appeals and grievances
- Requested PCP changes
- Emergency room use

Opioid Dashboard

Aetna has developed an enterprise-wide opioid strategy to impact every aspect of awareness, delivery, and use of opioids. We focus on treatment options including MAT as well as reducing the supply of opioids and decrease the rates of overdose. Our strategic solutions include prevention, intervention, and support components for enrollees and providers, thus addressing

the continuum of needs in an enrollee-centered manner. Aetna's national Medicaid organization recently introduced our opioid dashboard that provides national and state-specific progress towards our project goals.

Aetna's experience with our Medicaid plans nationally is that we have increased MAT access from 2017 to 2020 by on average 35%.

The West Virginia-specific opioid dashboard metrics based on pharmacy claims provided by the State of West Virginia and Aetna West Virginia Medicaid medical claims is summarized below and demonstrates our West Virginia plan's progression towards meeting the Aetna five-year plan 2022 goals based on the Center for Disease Control guidelines[2]. **Table 6.9.1-9** provides examples of content on our opioid dashboard including metrics, target goals, and West Virginia's performance metrics including the following:

- Increasing our rate of treatment with non-opioid procedures for chronic pain; the goal is a 50 percent increase over baseline and Aetna in West Virginia exceeds the goal with a 51.5 percent increase
- Decreasing our rate of opioid prescriptions in enrollees with opioid use disorder; the goal is a 50 percent decrease over baseline and Aetna in West Virginia is approaching the goal with a 44.9 percent decrease
- Decreasing our rate of concomitant opioid and benzodiazepine use; our goal is a 50 percent decrease from baseline and Aetna in West Virginia is approaching the goal with a 36.1 percent decrease from baseline

Table 6.9.1-9: Opioid Dashboard Metrics for West Virginia

Metric	Goal	West Virginia Metrics as of August 2019
Increasing our rate of treatment with non-opioid procedures for chronic pain	50%	51.5%
Decreasing our rate of opioid prescriptions in enrollees with opioid use disorder	50%	44.9%

[2] Dowell, Deborah, Haegerich, Tamera M, Chou, Roger, "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016," Morbidity and Mortality Weekly Report, 65 (No. RR-1):1–49 (2016): https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm; accessed January 20, 2020.

Metric	Goal	West Virginia Metrics as of August 2019
Decreasing our rate of concomitant opioid and benzodiazepine use	50%	36.1%

Member Advisory Committee and Focus Groups

Our MAC is designed to solicit member feedback and opinions regarding issues related to access and the quality of care and services provided to different populations within our membership as well as potential programs, activities, and educational materials representing the vast majority of enrollee needs, including individuals with special health care needs. We pull member records for all populations by ZIP code and mail 200 to 300 invitations to members in the area surrounding the meeting location. In order to encourage state-wide participation, we host MAC meetings in a different region of the state each quarter and offer incentives for participation.

Our 2020 MAC calendar is depicted in **Table 6.9.1-10** covering all West Virginia regions. Additionally, we will be conducting 4 focus groups for the MHT, WVHB, and WVCHIP populations and 12 topical focus groups throughout the West Virginia for our parents/guardians involved in foster care. Our Care Management staff identify and engage members; we supplement that list of members by pulling member records by ZIP code and sending 100 to 300 invitations to members. Our focus group design will ensure all segments are represented at these meetings to receive their valuable input and feedback.

Table 6.9.1-10: Aetna's 2020 Member Advisory Committee

Region	Location	Date
Southeastern	Shoneys, 460 Oakvale Road, Princeton, West Virginia	March 26, 2020

Region	Location	Date
Northeastern	Golden Corral, 625 Foxcroft Road, Martinsburg, West Virginia	June 25, 2020
North Central	Shoneys, 131 Woodward Drive, Sutton (Flatwoods), West Virginia	September 24, 2020
South Central	Lincoln Primary Care, 7400 Lynn Avenue, Hamlin, West Virginia	December 17, 2020

Member Satisfaction Surveys

Aetna regularly tracks and monitors accessibility of services, including for our special health care needs populations. The CAHPS survey captures data related to appointment availability, which will be used to identify and address barriers to care for children with special needs. Aetna is in the process of implementing the CAHPS survey item set for children with chronic conditions to identify barriers to care for individuals with special health care needs for our children and youth in the foster care system and individuals receiving adoption assistance. This version of the CAHPS survey expands beyond the standard CAHPS child survey to assess areas related to health providers contacting school or daycare center about the child's health, special medical equipment, special therapy such as physical/occupational/speech therapy, and offerings of counseling for emotional, developmental, or behavioral problems. Understanding issues from this survey may bring to light opportunities to support children who are moving between the Medicaid/WVCHIP and the foster care programs. In addition, we capture member satisfaction through the BH member satisfaction survey, which evaluates member experiences for BH care services, including questions related to member experience with accessibility, communication, practitioner satisfaction, member services, and overall satisfaction with BH and SUD care services. Aetna also uses information from complaint and appeals data for trending and analysis

that may be correlated with member survey data in the assessment of opportunities for improvement and for the development of action plans for both PH and BH.

Aggregate Utilization Data

Aetna uses multiple data sources to monitor appropriate health care utilization for different populations. We use UM reports and dashboards to monitor utilization data to identify trends that fall outside defined parameters and take action to address the trend. When we see these trends, we collaborate with the provider to identify the root cause and develop an intervention to address the trend and then monitor to assess the effect. Specifically, we use this aggregate utilization data to identify opportunities to identify and address barriers to care for different populations including individuals with special needs. Aetna's network director is responsible for identifying network gaps and opportunities for improving and monitoring to make sure identified needs are promptly acted upon. Aetna has an extensive suite of UM dashboards and reports with near real-time data to monitor appropriate utilization of services and cost-efficiencies including the following:

- **Demographic distribution for ER utilization dashboard:** This dashboard allows users to review ER utilization data through a demographic and health equity lens. The dashboard sorts and filters enrollees' ER utilization data to identify possible demographic-related disparities related to race, ethnicity, language, geography, or adverse incidents. We map where high ER utilizers reside, which allows us to assess local hospitals, urgent care centers, and providers with after-hours care to provide services to meet Aetna enrollee urgent health care needs. This provides for a region-specific, targeted approach to approach to provide access to care for enrollees needing immediate access to health care services.
- **UM performance dashboards:** We developed and use a suite of UM dashboards to monitor data reports including the following:
  - Readmissions
  - Time after discharge to follow-up appointment
  - Observations versus one- to two-day stays
  - ER utilization by facility, level billed, and primary system chief complaint
  - Neonatal intensive care unit admission patterns
  - Medical claims trends
  - Authorization trends
  - Inpatient performance to target trends
  - Length of stay

- **Pharmacy data analysis:** We conduct retrospective drug utilization reviews (RetroDUR) to detect pharmacy over-utilization. Aetna applies RetroDUR to assess drug over- and under-utilization patterns to drive the development of interventions and/or educational activities. Aetna also utilizes our pharmacy data received daily from the State for metrics including opioids and utilization; this information is shared between the PH and BH staff and providers.
- **Gaps-in-care reporting** as both an internal staff and external provider tool to address under-utilized services. As a health plan, we are evaluating gaps in care daily every time we interact with an enrollee. This allows us the opportunity to not only encourage needed care such as screening, well visits, or follow-up care, but also to assist in getting the enrollees to the visit. Based on the gaps in care report and indication of underutilization, we look at PCP assignment, high ER utilization, and readmission rates to determine if an enrollee needs specific outreach or resources in completing their care.

Tracking and Trending Complaints and Appeals

Aetna maintains records of all appeals, grievances, and State Fair Hearings within our internal, proprietary application. Our reporting suite enables us to monitor aging of cases in real time to make certain of timely resolution and to identify and report trends for potential opportunities for improvement. In addition, we will be able to identify complaints and grievance information directly pertaining to different populations including individuals with special health care needs and the WVCHIP population to help ensure timely response to issues.

Member Complaints

Aetna utilizes the NCQA complaint categories for tracking and analysis of complaint and appeal data for individuals with special health care needs and different populations. Examples of complaints that may be filed in each category are described in **Table 6.9.1-11.**

Table 6.9.1-11: NCQA Complaint Category and Examples

NCQA Category	Examples
Quality of Care	Treatment issues or the quality of the care the member received
Access	The member's access to care, such as lack of availability to a practitioner
Attitude and Service	The attitude of someone that rendered care to the member or the quality of the service the member received
Billing and Financial	Member receiving a bill/billing or financial issues (how services were paid or denied)

NCQA Category	Examples
Quality of Practitioner Office Site	The physical condition of a practitioner's office

Complaint and appeals data are evaluated at the population level, as well as that of plan, practitioner, facility, and provider levels. Documentation and analysis are presented during biweekly Complaint Committee and weekly Appeal Committee meetings as well as on a quarterly basis to the SIC.

In 2018, Aetna continuously identified opportunities for improvement after identifying root causes of dissatisfaction and barriers to improvement, including the following:

- Establishing a goal for provider relations staff to respond within seven days to each individual provider inquiry
- Ensuring proper tracking of complaints in 2019 through staff training and education on all aspects of their job and the expectations for their role
- Educating member services representatives on the difference between a complaint or an inquiry
- Having the Appeals and Grievance department work cohesively with the other departments throughout the year supplying them with the complaint information related to their department so it can be addressed real time; the expected outcome is to prevent errors in reporting and proactively prepare for the quarterly report as well as the annual analysis

Through feedback from the SIC and the Complaint Committee, Aetna developed an action plan and monitored activities to drive service improvements. The SIC and the Complaint Committee attempted to identify prospective barriers and potential issues when assessing complaint and appeal data. This data is used to develop the action plan for the upcoming year for improved performance.

Member Appeals

In support of member quality of care and satisfaction for individuals with special health care needs and different populations, all Aetna members have the right to appeal both coverage and non-coverage decisions. These rights are outlined in the Aetna member handbook and provided

to members upon enrollment and/or as requested/required. Appeals initiated by practitioners on behalf of members are included in member appeal data.

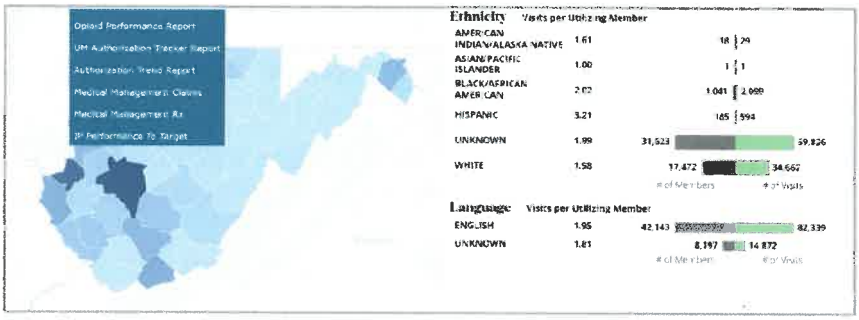
Tracking Members Requesting Changes in Primary Care Providers

Aetna currently tracks members selecting different providers through our call tracking process and PCP change reports and will be tracking this movement between PCPs for individuals with special health care needs and the WVCHIP population. When members or their caregivers and guardians request to change their PCP, the Member Services team completes a real-time change of PCP assignment while the member and/or guardian is on the line. We collect the volume of PCP request changes and will generate reports specific to individuals with special health care needs and different populations to assist in identifying request trends. These reports are reviewed by the SIC and compared to the general population over time. We track and trend requests for PCP changes by population to identify and correct any network adequacy concerns. If we identify a PQOC concern or complaint through a member's request to change PCPs, we immediately address the issue and refer it to the PQOC team to take action.

Tracking Access to Emergency Department Use

Most people, including those with Medicaid coverage, go to the ER for care when they feel they have no other option. Medicaid members often face more challenges accessing the health care system than non-Medicaid enrollees. As such, Medicaid enrollees tend to visit the ER more often than non-Medicaid enrollees. They may have SDOH issues which affect their ability to access care through traditional primary care office settings. Medicaid members often are living with higher rates of chronic diseases and co-occurring BH disorders. We help different populations access the primary and preventive care they need to avoid medical or BH crises that result in avoidable ER usage. Aetna's current UM dashboards allow drilldown monitoring of

ER usage by various parameters including age, gender, geographic region, and other membership characteristics as depicted in **Figure 6.9.1-8.** This data will be used to track access to ER use for individuals with special needs. The Care Management team will monitor this information on a monthly basis in order to rapidly identify potential access to care issues for individuals with special needs.



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Figure 6.9.1-8: Demographic Distribution of ER Utilization
This dashboard allows users to review ER utilization data through demographic and health equity lens where the user can sort and filter to identify and address possible demographic related disparities in ER utilization.

Individuals with special health care needs who seek non-emergent care in an ER may not be receiving the benefit of a medical home and the continuity and familiarity that a PCP or the appropriate specialist provider can offer. Our goal is to assist these enrollees with identifying and removing barriers. Our innovative solutions and flexible approach to integrated care management provide unique opportunities for improved health outcomes that meet and exceed State expectations. We use our integrated care management program to address inappropriate ER utilization with enrollees through the following process:

- Care coordinators access informatics reports that identify enrollees with special health care needs who have utilized ER services
- Our care coordinators outreach to individuals with special health care needs who have used the ER to evaluate the individual's needs and how they can be assisted.
- Care coordinators identify barriers that prevent our enrollees from receiving care in their medical home or outpatient specialist office, such as transportation, work schedules, or social support.
- Care coordinators discuss the enrollee benefits of maintaining regular care with a PCP to avoid seeking non-emergency services in the ER

10. Claims and Encounters

The Vendor should refer to the business specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Claims and Encounters (CE) as part of their bid. The Vendor's narrative response should not exceed 50 pages.

Aetna is committed to continuing to meet and exceed the West Virginia Bureau for Medical Services' (Department) goals for claims submission and adjudication to payment timeliness.

Claims Processing Guidelines and Systems Requirements

CE001	The Vendor should describe its claims processing guidelines and systems requirements that ensure timely payment of all clean electronic and paper claims for covered services from both in-network and out-of-network providers, within thirty calendar days of receipt for Mountain Health Trust (MHT) members.

Aetna's claims adjudication system ensures timely payment of clean claims for both in-network and out-of-network providers through a hierarchical rules-based system containing all West Virginia claims rules, payment rates, and claim adjudication edits. The claims system is a Health Insurance Portability and Accountability Act (HIPAA)-compliant system we use to maintain and process health care administration data, which enables us to increase administrative efficiency and improve the quality of care.

Description of Claims Processing Guidelines

Our claims processing guidelines consist of procedures and policies to meet all regulatory and contractual requirements: strategies to address provider payment issues; monitoring of claims receipts to enhance claims resolution; underpayment and overpayment review and resolution to ensure that we and our subcontractors follow established benchmarks; pre-and post-claims editing policies to support the detection of coding irregularities, conflicts, or errors and make correction suggestions; and provider billing education to provide targeted training to our provider community and improve the provider experience. We support our claims processing

commitment through our focused claims inventory and workflow management practices, data monitoring and analysis, and management oversight efforts as illustrated in **Figure 6.10.1-1**.

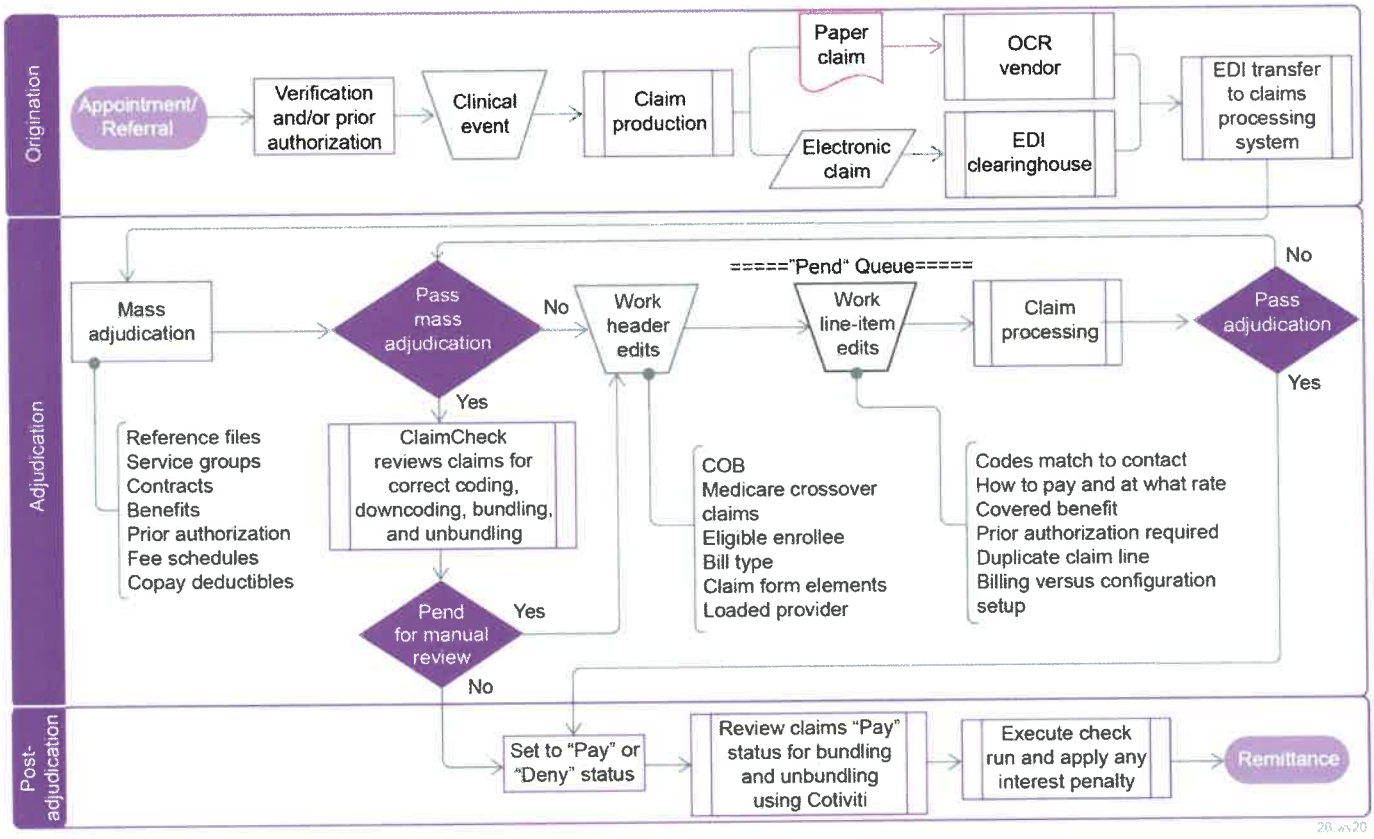


Figure 6.10.1-1: Life of a Claim

Our end-to-end claims processing workflow ensures timely and accurate claims payment.

We offer our providers multiple clearinghouses for electronic claim submission, which provides a broad range of submission options. Provider education and training on general claims submission and requirements (e.g., encounter submission requirements, electronic data interface claims, Medicaid identification registration, etc.) are accessed easily through the provider portal on our website and through our local Provider Relations team.

Over the last 12 months, our average **turnaround time** for electronic data interface claims **is 8 days**. Our average turnaround time for paper claims is 13 days.

Aetna understands and will implement processes to comply with the Department's requirement to process clean claims within 30 calendar days for both in and out-of-network providers.

In support of these requirements, we generate weekly payment cycles for medical claim payments. **Table 6.10.1-1** summarizes our consistently high rate of claims processing performance and our compliance with timely processing of the Department's 30-day claims payment requirements from January 2019 through December 2019.

Table 6.10.1-1: West Virginia Claims Processing Performance

	Days to Pay		30 Days		90 Days	
Month	Electronic Data Interface Claims: Average Days to Pay	Paper Claims: Average Days to Pay	Total Claims Processed in 30 Days	Percent of Claims Processed in 30 Days	Total Claims Processed in 90 Days	Percent of Claims Processed in 90 Days
Dec-19	9	13	207,597	97.86%	212,084	99.97%
Nov-19	9	11	225,769	98.23%	229,835	100.00%
Oct-19	8	9	272,070	99.39%	273,730	100.00%
Sep-19	8	10	212,729	99.63%	213,507	100.00%
Aug-19	8	10	193,855	99.83%	194,186	100.00%
Jul-19	8	11	217,999	99.76%	218,527	100.00%
Jun-19	8	13	167,619	99.53%	168,386	100.00%
May-19	8	12	181,594	99.39%	182,613	99.95%
Apr-19	8	13	217,735	99.25%	219,360	99.99%
Mar-19	8	13	183,758	99.35%	184,926	99.98%
Feb-19	8	14	184,795	99.06%	185,536	99.99%
Jan-19	9	14	186,181	99.01%	188,037	100.00%

Policies and Procedures to Meet Standards and Requirements

Our claims administration policies and procedures (P&Ps) are crucial to meeting or exceeding our accuracy, timeliness, and completeness to fulfill the Department's requirements and

changing needs. These P&Ps include claims submissions, data entry, claims manual adjudication, processing of non-contracted provider claims, and claims inventory management (please refer to **Figure 6.10.1-2**). We adhere to all state and federal prompt pay guidelines and we review all Aetna policies at least annually (within 12 calendar months of last reviewed/revised date). We may update our policies more frequently if there are changes to the contract, federal, state, or other regulatory requirements, or Aetna business processes. The Aetna Medicaid organization policy committee reviews all policy updates and requires approval from Aetna Medicaid Administrators, chief operating officer (COO), and chief medical officer (CMO) prior to publication of the documents. The following list summarizes policies and procedures applicable for this program:

- **2000.05 Data Entry:** Documents processes used by the data entry team to facilitate timely and accurate data entry of paper claims and non-standard claim forms by verifying claim data, manually entering claims that cannot be imported electronically, sending claims that need additional review to the appropriate unit, and returning claims that lack sufficient billing information to the provider. The data entry process optimizes the timely and accurate entry of paper claims and non-standard claim forms.
- **2000.10 Claims Adjudication:** Documents claims processes to facilitate claim adjudication in a timely and accurate manner, according to Department and health plan standards and federal requirements. Through the auto-adjudication process, pre-determined edits systematically pend to designated categories for manual processing. Claims that require manual processing are typically more complex claims, where our team of experienced claims processors works to quickly resolve and eliminate claim-related errors to avoid any detrimental impact on the provider.
- **2000.20 Claims Submission:** The purpose of the claims submission policy is to ensure paper and electronic claims are submitted and accepted into the claims processing system in a timely and accurate manner, according to Department and health plan standards and federal requirements. Our Claims team manages the submission process, identifies how paper and electronic claims are received and prepared electronically for manual or auto-adjudication, and maximizes our compliance with Department and federal regulations.

Our Claims Processing team's performance is exceptional:

- We auto-adjudicate 88% of claims
- Our 2019 payment and procedural financial accuracy rate was 99%
- Our team averages 11 years of claims processing experience (per hire date)

- **2000.30 Non-contracted (Out-of-Network) Provider Claims:** Defines the adjudication process for claims from non-contracted providers, either manually or through mass auto-adjudication in a timely and accurate manner according to the Centers for Medicare & Medicaid Services (CMS) regulations, Department, and health plan standards. Our Claims department is the primary coordinator of all claim adjudication activities for out-of-network providers. Our out-of-network provider process complies with federal laws and regulations by issuing appropriate claim determinations, which includes developing claims for additional information whenever needed, including for services received from out-of-network providers that were authorized by a contracted provider or Aetna for services.
- **2100.15 Claims Inventory Management:** The claim inventory management policy confirms proper inventory control for timely claims payment. This process maintains accountability for the control of the claim inventory to arrange timely claims payment. Our claims management personnel are responsible for managing the claims inventory using various reporting tools and conducting weekly meetings with the health plan to discuss resolution of aging claim inventory.
- **3900.30 Reporting and Return of Overpayments:** This policy implements processes to confirm and document compliance with Department and federal regulations regarding the timely identification, reporting, and refund of overpayments. This process ensures that the health plan receipts are reviewed monthly and consists of reconciliation of member enrollment information to received capitation payments, identification, and resolution of overpayments. Health plan representatives are required to certify receipts have been reviewed and overpayments have been identified on a quarterly basis.
- **6200.10 Provider Claim Payment and Data Completeness:** This policy documents requirements and standards for claims payment, data completeness, and clarifies the network provider requirements for the submission of claim and encounter data. Providers and subcontractors are contractually required to submit clean claims to Aetna within 365 calendar days from the date of service. Providers are also required to supply additional information reasonably requested by Aetna to verify that the provider-rendered covered services, that the charges are usual and customary charges for such services, and that the services rendered were appropriate. Hospitals must submit claims for reimbursement and encounter forms on a UB-40 Form and must submit bills to Aetna within 365 days of the date of discharge.

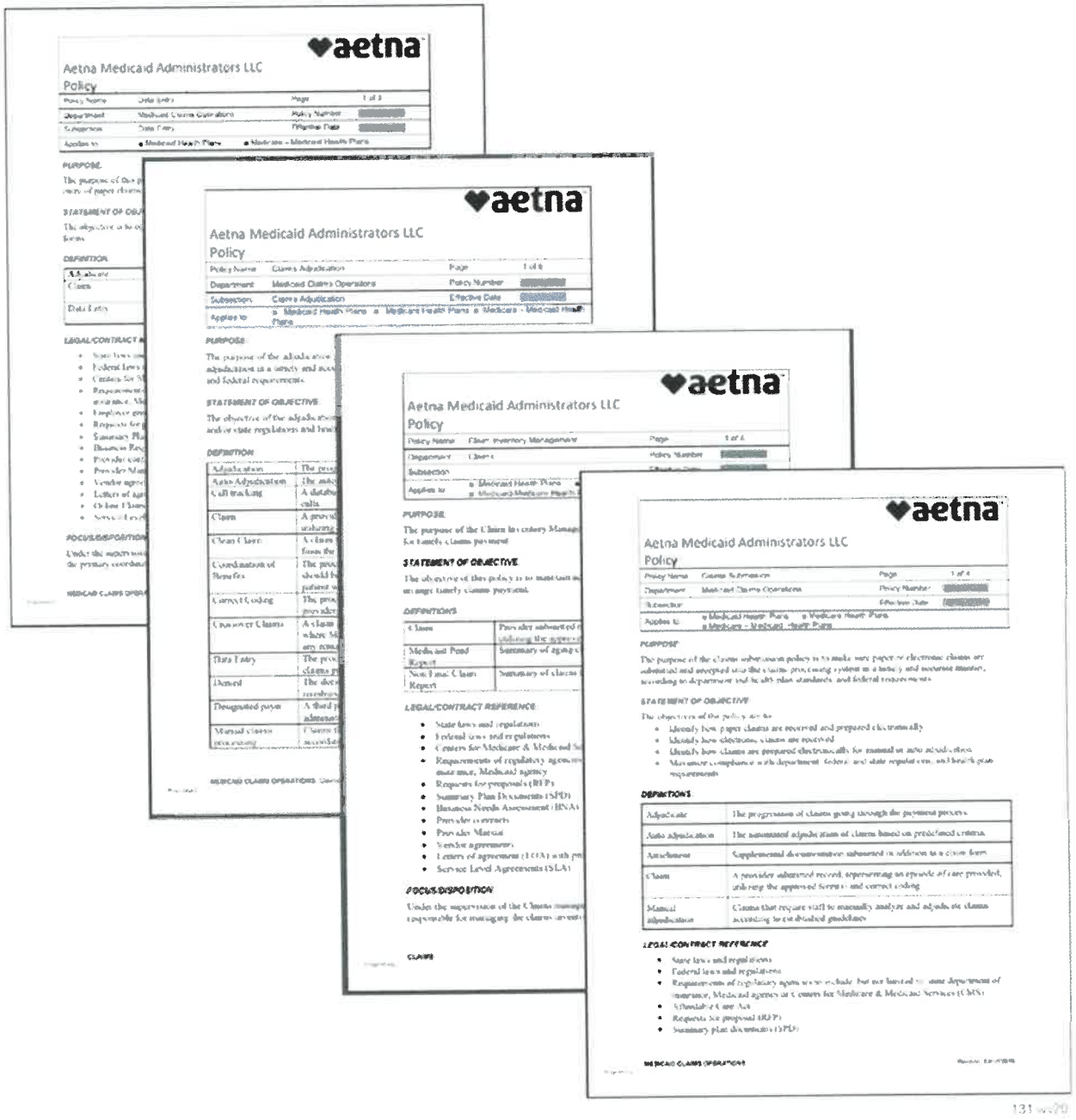


Figure 6.10.1-2: Aetna Claims Processing Policies

Aetna maintains a comprehensive set of claims processing policies that we use to meet our accuracy, timeliness, and completeness to our members and providers and our contractual commitments to the Department.

Claims Processing Guidelines

Our Provider Relations team implements innovative approaches using technology and reporting to provide targeted training to our provider community and improve the provider experience.

This team uses on-demand reporting and analytics to identify trends specific to claims denials, coding errors, and gaps-in-care reporting by a member panel. Often this analysis results in the identification of opportunities to educate providers and the need for technical assistance to address and remedy claims denials/errors. In some cases, we initiate provider-specific claims projects to remediate claims errors quickly, which facilitates timely claims payment for the provider. Our risk adjustment training includes defining risk adjustment, its goals, risk scores, the calculation methodology, their impact on revenue, and how coding and encounter reporting are critical components of risk adjustment.

We also use this information as source data for newsletters, news bulletins (provider website/portals), and educational opportunities during our quarterly existing provider training webinar. For ongoing provider training and technical assistance, we use webinars for our monthly provider meetings. We also host regional provider forums where we invite guest speakers to present on best practices, system initiatives, and other topics relevant to serving West Virginia members. We share information on claims edits with providers.

Upon review of our 837 state encounter denial report, our Encounter department researched and identified a group of providers that were billing with an expired bill type. Our provider relations manager ensured that the groups of providers were contacted and received education on the CMS' changes to the bill type. We also initiated a claims retractions project, which allowed these providers to rebill the corrected claims using the valid service code. We then worked with our Claims Management department to insert a system check that would auto-correct the expired billing code on future claims.

We furnish providers with toll-free numbers to contact our provider or claims inquiry and research call centers. Providers also have a direct number to reach their designated provider relations representative and they may also use email, secured web portal, fax, or mail to contact us.

Underpayment and overpayment

Our established policies and procedures help ensure that we and our subcontractors follow established benchmarks. We review and validate monthly health plan receipts against contractual requirements, and we account for these same receipts within health plan financial statements. We submit our financial statements to applicable regulatory agencies in accordance with payor requirements. We also report all identified overpayments to applicable state or federal agencies within 45 days of identification. Annually, our plan leadership certify compliance with the requirements outlined in this policy.

This approach helps us proactively manage and analyze prompt reporting of all overpayments identified or recovered, including overpayments due to potential fraud, to the Department as required by 42 C.F.R. 447.46 and 42 C.F.R. 447.45. Additionally, we administer all recovery of overpayments and underpayments in accordance with the Department's requirements. We coordinate over- or under-payment reimbursement with the Department to ensure payment recovery is reflected accurately in medical loss ratio calculations and capitation rate setting. Our specific encounter processes help ensure compliance with West Virginia requirements and include claims submissions, data entry, claims manual adjudication, processing of non-contracted provider claims, and claims inventory management.

Pre- and post-claim editing

We collaborate with industry leaders, Change Healthcare and Cotiviti Healthcare, for front-end automation of correct-coding and medical-policy decisions. This approach supports the detection of coding irregularities, conflicts, or errors while making recommendations for correction. Our claims platform and these vendors perform the following claim edits:

- Enrollee data (e.g., age, gender) and provider data

- Current coding protocol, including national correct coding initiative code-to-code pairs, validation of diagnosis (International Classification of Diseases 9/10), the American Medical Association's Current Procedural Terminology Manual® (CPT), health care common procedure coding system I/II, revenue codes, modifiers, procedure code definition and guidelines, multiple-procedure reductions, add-on logic based on CPT guidelines, procedure unbundling, mutually exclusive procedures, assistant surgeon, place of service, type of bill, medical visit logic, medical unlikeliness, durable medical equipment, new-visit frequency, professional, technical, and global services.

These edits use historical claims information to detect and correct questionable billing practices and to assist in identifying patterns of fraud, waste, and abuse concerns such as duplicate billing. Cotiviti also performs a clinical chart review if improper billing or potential fraud, waste, or abuse is identified and contacts the provider for adjustment or recoupment as needed.

Strategies to Address Provider Payment Issues

We continuously analyze our claims payment system to determine what additional editing needs to be configured in support of the state-specific requirements of this program. Aetna's Claims department maintains a Claims Inquiry Claims Research (CICR) Line, a toll-free number that network providers are free to call between the hours of 8:00 a.m. and 5:00 p.m. to speak with Claims Research Line personnel. CICR representatives are specifically designated to answer provider phone inquiries regarding claims status, track those inquiries within QNXT's call tracking functionality, and provide status and/or process adjustments to previously processed claims accordingly. If the inquiry results in the identification of a system issue, this is reported and managed through our issue identification process. Providers are notified when final resolution is achieved. This effort enables us to address any potential provider payment issues and provide billing education.

CICR uses an all-inclusive call tracking report that tracks the details for every call we receive. This report enables us to sort and monitor our call performance by department, call description,

reason code, provider, and other fields. Additional tracking reports we generate include our call tracking rework inventory, which organizes our rework inventory and age, as well as our providers with 10+ calls made to us. We use this report to monitor and identify providers who may have billing or other issues and might benefit from one-on-one billing education and training.

We also use a suite of automated tools and the following scheduled and ad hoc reports to monitor claim receipts:

- Pended claims tool and reports: These include all claims that fail auto-adjudication or are suspended for manual review; the claims manager reviews hourly to balance workload. For example, if a claim is with another department, once the claim is pended back to our claims team; if the claim is aging, the manager can assign the claim out as soon as the claim status refreshes on the report to ensure the claim is paid timely.
- Inventory aging report: A daily inventory report is created for the health plan to help with prioritization. An example is if a claim for a specific provider needs to be addressed, the health plan can review this report and reach out to the claim manager to have a claim pulled and processed.
- Non-final claims tool and reports: Identifies claims in any status other than those finalized. An example is the claims manager or a member of the health plan team can review a claim prior to it being finalized and make changes if necessary.
- Claims performance reporting: Monitors turnaround time for clean claims and provides a history of performance; for example, the Claim Management team as well as the health plan will use this report to ensure all Department requirements are being met.

We use these reports to distribute and manage claims through resolution. If any of the inventory management reports indicate a less than favorable trend, we take corrective action steps immediately. For example, aged claims remediation steps include the use of overtime hours, temporary labor, and workload balancing of trained operational staff across all Claims Operations departments, and if necessary, all Operations departments. Additionally, we investigate and implement any systematic intervention opportunities by Information Technology department to enhance claim processing in collaboration with our claim payment director.

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

Description of System Requirements

Aetna's claims processing system handles claims, eligibility, member enrollment, service authorization, provider enrollment, and data management functions—as well as edits that align with claim processing and payment data, encounter data reporting requirements, member and provider service tracking, contract configuration, and reference file management. These system components allow for timely and accurate claim payments to meet regulatory and contractual requirements.

Claims Processing System Capabilities

Our claims processing system includes 28 integrated modules that maintain and process health care administration data. This system contains every data element required for claims data adjudication. It is a claims hierarchical rules engine that was built with a feature-flagging design (rules for claims processing with a minimum disruption of services) that enables us to rapidly adjust the configuration to provide flexibility while minimizing down time and providing greater platform responsiveness. We have programmed West Virginia claims import rules into the application, and the application is built to ease turning rules and configuration characteristics on and off, as needed, without affecting the entire system, further ensuring service continuity. Additionally, we configure our claim adjudication edits within the claims processing system to validate the accuracy and completeness of data allowing for the seamless encounter submission. Our system includes over 400 business rules in addition to standard configuration payment rules that our Configuration Standards Reimbursement Administration (CSRA) department configures to enforce policies and procedures.

Our claims processing guidelines and system requirements ensure timely and accurate payment of all clean electronic and paper claims for our in-network and out-of-network providers.

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

Processing Contractually Obligated Services at Prevailing Rates

CE002	The Vendor should describe its claims processing guidelines for contractually obligated services to ensure that claims are paid at no less than 100% of the prevailing rate for Mountain Health Trust (MHT) Medicaid or West Virginia Children's Health Insurance Program (WVCHIP) Fee-for-Service (FFS) rate(s), as applicable.

Aetna maintains an approved process for processing contractually obligated services at prevailing rates (please refer to **Table 6.10.1-2**). We initiate a fee schedule update process when we receive a covered services fee schedule from the Department. We review any updates to the fee schedule and then forward the list to our CSRA department, which will load the rates into our system. We update any new codes and process any claims via claims projects for any retroactive fee schedule changes. We maintain the rates by system update requests for each subsequent change generated by the Department.

Weekly, as health plan payments are processed, the health plan's chief financial officer (CFO) oversees the review of provider payments. Our Medicaid Claims Audit department staff will randomly select paid claims on a monthly basis, validating the appropriateness of payment.

Table 6.10.1-2: Fee Schedule Adjustment Process

Step	Action
1.	Aetna receives an email notification of rate change and/or fee schedule update is received from West Virginia Medicaid/Bureau of Medical Services.
2.	Upon receipt of this email, Aetna's operations manager reviews the update for accuracy/intent and log receipt of the notification on Aetna's internal status reporting site.
3.	Per Aetna's contract with the Department, rate updates must be in the system and reflected in claim payments within 30 days of receipt.
4.	After review, the project manager will submit a health plan assistance request form to the Health Plan Reimbursement Administration department to have the rate or fee schedule update completed in QNXT.

Processing Preventable Provider Conditions and/or Hospital Acquired Conditions Claims

CE003	The Vendor should describe its claims processing guidelines that ensure the denial of claims payment for preventable provider and/or hospital acquired conditions as defined under Section 2702(a) of the Affordable Care Act (ACA) (https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf).

Our claims processing system contains rules and edits to identify and pend payment for claims arising from preventable provider or hospital acquired conditions, which we have successfully applied to applicable claims during our current contract with West Virginia. This particular claims process stops automatic processing of claims that we identify for clinical review per Aetna business standards. We use this process to pend claims received with provider preventable conditions (PPC) related diagnosis codes. We refer pended claims to a concurrent review nurse, who then initiates an investigation process. In addition, associates involved with the concurrent review process may identify potential PPCs during utilization management evaluation.

An Aetna concurrent review clinician identifies possible PPC claims when the following conditions are present in any health care setting:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient
- Other provider preventable conditions identified in the State's plan and according to the requirements of the final regulation

Based on PPC findings from the CMO or designated medical director the claims analyst proceeds with processing of the claim in accordance with claims processing standards for PPC and denies the claim if applicable.

Our Quality Management department and Utilization Management department teams are responsible for monitoring, tracking, and trending all PPC referrals. These teams analyze PPC referral trend data, including recommendations for intervention strategies for areas of noted

concern, and report these results on a quarterly basis to our Quality Management/Utilization Management (QM/UM) Committee.

Rate Change Implementation Process

CE004	The Vendor should describe how they will implement rate changes adopted by the Department within thirty calendar days of notification of the rate change.

Our established policies and procedures for rate change implementations ensure that rates within our claims processing system are accurate and completed in a timely manner (please see **Table 6.10.1-3**). Our CSRA department reviews the rate change received from the Department via a request from the Department's system change request. This process includes logging all submitted rate changes into our workflow tracking system upon receipt, where we perform an analysis of current set-up and needed changes, document the findings and solution, route the request for appropriate approvals, and complete the updates in the appropriate development environment.

Once we complete this system change request process, our Medicaid program solutions team starts a claims-testing process against the systems change request form requirements. If, after we complete this analysis, the CSRA department's testing recommendation differs from the local health plan's request, the CSRA department's staff will contact the local health plan for further discussion regarding the requirements. After our Solutions team completes and the development build is approved, the CSRA department staff initiates the promotion request for the Information Technology department to promote changes to the production environment. When appropriate, our CSRA department staff run a post-production query to identify impacted claims. The final step of this process is to notify the original requestor that the requested changes have been completed.

Table 6.10.1-3. Rate and Fee Schedule Update Procedure

Role	Input Source	Process	Output	Hand-off to:	Metric
COO / CEO / Operations Manager	Email notification of rate / fee schedule update	Email notification of rate change and/or fee schedule update is received from the Department.	Email	Operations department	As received
Operations Manager	Receipt of email outlining rate or fee schedule change	• Upon receipt, the operations manager will review the update for accuracy / intent and log receipt of the notification on the hub. • Per the contract with the Department, rate updates must be in the system and reflected in claim payments within 30 days of receipt. • Clear subject, receipt date, effective dates, etc.	Tracking log / linked notification into the log	Project Manager	Within 2 business days
Project Manager	Email with intent of update / request	After review, the project manager will submit a health	Health plan assistance request form	Health Plan Reimbursement Administration department	30 days

Role	Input Source	Process	Output	Hand-off to:	Metric
		plan assistance request form to our Health Plan Reimbursement Administration department to have the rate or fee schedule update completed in QNXT.			

NCCI and Related Claims Processing Systems and Guidelines

CE005	The Vendor should describe how its claims processing systems and guidelines uphold payment policies that comport with the National Correct Coding Initiatives (NCCI) edits and/or other claims payment guidance defined by the Centers for Medicare & Medicaid Services (CMS) (https://www.cms.gov/medicare/coding/nationalcorrectcodinited/index.html).

Aetna adheres to the payment policies of the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) as well as the CMS claims payment guidance by incorporating ClaimCheck® edits in our claim adjudication process. These claims processing edits and tools are designed to maximize accuracy throughout the adjudication process. ClaimCheck is a comprehensive code auditing solution based on guidelines such as CPT, the CMS Healthcare Common Procedure Coding System Level I/II (HCPCS), American Medical Association (AMA), NCCI, CMS National Correct Coding Initiative Program Medically Unlikely Edits (MUE), and International Statistical Classification of Diseases and Related Health Problems, v10-CM (ICD v10-CM). These guidelines support the claims processing system by applying expert industry edits from a provider-recognized knowledgebase to analyze claims for accuracy and consistency with relevant policies and procedures.

The CMS developed the NCCI to promote national correct coding methodologies and to eliminate improper coding. The development of NCCI edits by the CMS is based on CPT coding conventions, current standards of medical surgical coding practice, input from specialty societies, and analysis of current coding practices.

Our claims payment process incorporates NCCI incidental and NCCI mutually exclusive auditing processes. NCCI mutually exclusive edits consist of those edits located in the NCCI Column 1/Column 2 edits that include a policy statement defined as mutually exclusive procedures. NCCI incidental edits consist of those edits located in the CCI Column 1/Column 2 edits with policy statements other than those defined as mutually exclusive procedures. In ClaimCheck, an updated NCCI knowledgebase is available on a quarterly basis.

Our ClaimCheck clinical editing software identifies coding errors in the categories, including 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, and medically unlikely services. Aetna also uses integrated claims management services, powered by Cotiviti, to enhance the claim processing system's edit functionality for professional claims that reach an adjudicated status of 'Pay.' Cotiviti has robust coding rule sets that support Medicare NCCI/MUE, Medicaid NCCI/MUE, ICD v10-CM, NCCI Institute of Medicine manuals (internet-only), AMA, HCPCS, and national and local coverage determinations as well as health plan policies. Our system uses algorithms to detect potential claims up-coding with follow-up procedures for chart audits as appropriate. **Table 6.10.1-4** includes examples.

Table 6.10.1-4: Cotiviti's Claim Processing System's Edit Functionality

System Capabilities	Description
Coding accuracy	If services are upcoded or unbundled, Cotiviti alerts the Claims department to deny the claim line along with the specific clinical editing policy justification. The claim line denies with the appropriate HIPAA remittance remark on the recipient of medical benefit. An example of the denial remittance remarks we use are 97. The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated; N19 – procedure code incidental to primary procedure; and M80 – not covered when performed during the same session/date as a previously processed service for the patient.
Durable medical equipment (DME) editing	Cotiviti performs edits related to select DME payment policies that align with Medicaid-covered service policies. These edits include DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps, and anatomic/functional modifiers required for DME services—for example: DME editing inconsistency between accessories and wheelchair type. Manual wheelchair and power wheelchair accessories are not appropriate for use with each other and will be denied when billed together by any provider for the same date of service.
Procedure code guidelines	Aetna follows the CPT and HCPCS for instructions on code usage. Cotiviti has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, we deny the code as inappropriate based on industry standards. According to the CPT, this vaccination must be reported in addition to the vaccine and toxoid code(s). Cotiviti has developed these guidelines into specific policies. For example: Per CPT guidelines (CPT codes 98966-98969), non-face-to-face nonphysician services should only be allowed once per seven-day period. We will deny additional billing submitted for the same billing period.

Cotiviti supports correct coding based on the definition or nature of a procedure code/combination of procedure codes. The ability to code in this manner supports prior authorization requirements during claim adjudication. Furthermore, these editing policies either bundle or recode procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, Cotiviti applies editing logic that bundles all the

procedures billed into the most appropriate code. If a provider bills an office visit and bills separately for heart monitoring with a stethoscope at the same visit, Cotiviti re-bundles the service into the appropriate evaluation and management or office code.

Using the edits and tools described in this section, we deny, completely or in part, claims with missing or invalid information. Providers and subcontractors are required to resubmit the claim with valid information to receive payment. We configure our claim system to align with the Department's services coverage and payment policies. When we deny claims at submission, configuration is added to align with their guidelines as well. In such instances, we require providers or subcontractors to resubmit the claim with valid information to receive payment. Aetna-contracted providers that have a claim denied in whole or in part are also notified of applicable appeal and grievance rights, which we address and resolve through our established provider grievance and appeals process.

Guidelines for Waiving Member Copayment or Cost-Sharing

CE006	The Vendor should describe its claims processing guidelines and systems requirements that waive member co-payment or cost-sharing obligations for all applicable populations and covered services.

Our claims processing system is built to apply co-payments or cost-sharing obligations at the individual member and family member level by utilizing the member's benefit level (please refer to **Figure 6.10.1-3**). The benefit setup procedure for our claims processing system ensures the member's correct co-payment/coinsurance amount is applied to claims based upon the claim payment amount. The claims processing system also tracks the member's out-of-pocket history at an individual and family level based upon the head of household indicated on the Department enrollment file.

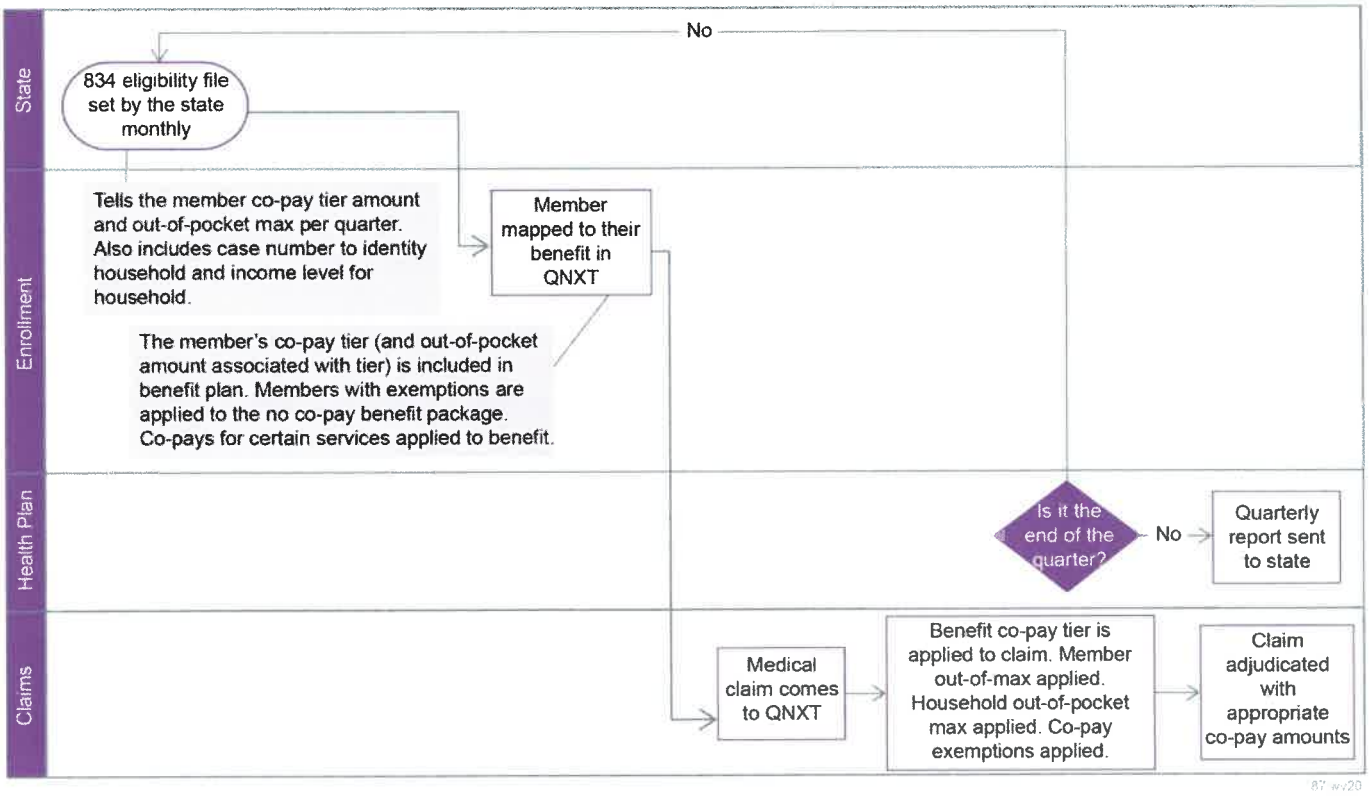


Figure 6.10.1-3: Claims Copayment Process
Our end-to-end claims processing workflow ensures members' copayments and cost sharing rules are applied appropriately so members pay the contracted amount.

Aetna does not waive members copayments; however, our contract includes a list of members and covered services that are exempt from this practice. The following list shows exempt members and covered services:

- Family planning services
- Emergency services
- Behavioral health services
- Members under age twenty-one
- Pregnant women (including the 60-day postpartum period following the end of pregnancy)
- American Indians and Alaska Natives
- Members receiving hospice care
- Members in nursing homes
- Any additional members or services excluded under the Department
- Members who have met their household maximum limit for the cost-sharing obligations per calendar quarter

In addition, Aetna and Aetna providers must charge copays for the following covered services or members:

- Inpatient and outpatient services
- Physician office visits, including but not limited to office visits to a nurse practitioner
- Non-emergency use of an emergency room
- Caretaker relatives age twenty-one and up
- Transitional Medicaid members age twenty-one and up
- Any other members identified by the managed care organizations that are not specifically exempt

Process to evaluate data quality of Claims/Encounter Data

CE007	The Vendor should describe its process to evaluate the data quality of its claims/encounters submissions to the Department including, but not limited to, the formatting and all data elements required to complete compliant 837 electronic transactions for medical and dental claims.

Aetna ensures our claim and encounter data quality through provider contracting and education; applying comprehensive claims editing; and through our robust encounter management system and experienced staff.

Provider contracting and education

Our encounter validation process begins with the delivery of services, where we require participating providers to submit encounter data with a clearly defined set of provider- and service-based information. We educate providers about our claims system upon contract agreement during provider orientation and Provider Relations training sessions and through our regular communication channels. These efforts address claim submission issues and clean claim submission requirements to support timely payments to providers and encounter accuracy.

Comprehensive Claim Editing

Our claims adjudication system validates and requires key data fields be provided at the claim level in order to adjudicate. These data field requirements include but are not limited to the following:

- Recipient Medicaid identification number
- Provider Medicaid identifier and national provider identifier
- Claim type
- Place of service/bill type
- Revenue codes
- Procedure codes (CPT)
- Diagnosis code(s) (ICD v10-CM)
- HCPCS
- Modifiers
- Dates
- Charges

Our claim adjudication system validates the accuracy and completeness of encounter data, which supports our seamless submission of encounter data to the Department. This system contains over 400 business rules, which are in addition to standard configuration payment rules that our CSRA department configures to enforce policies and procedures. Examples include the following payment rules:

- **Benefits package variations:** Our claims processing system automatically analyzes CPT, revenue, and HCPCS to determine whether specific services are covered under the contract or under benefit rules. If a service is not covered by HealthChoices, our system automatically denies the respective claim line with the appropriate HIPAA remittance remark on the recipient explanation of medical benefits.
- **Data accuracy:** We continuously update our claims processing system based on current code sets (e.g., HCPCS, revenue, CPT, National Drug Code, ICD v10-CM codes), so our system is always in compliance with HIPAA standards. If a provider bills a terminated code, we deny the claim line and advise the provider the code is invalid via remittance advice.
- **Eligibility and enrollment:** Our claims processing system validates the date of service against the member's enrollment segment to verify member eligibility on the date of service. If the member is not eligible, the system denies the claim using the appropriate HIPAA remittance comment.
- **Coding validation edits:** We use Cotiviti and ClaimCheck claims processing edits and tools to maximize adjudication accuracy. Cotiviti supports our front-end automation to support correct coding and medical-policy decisions. ClaimCheck is a code auditing solution that applies expert industry edits from a provider-recognized knowledgebase to analyze claim accuracy and consistency with relevant policies and procedures.
- **Adherence to state-specific requirements:** Our system is configured to enforce the rules and requirements set forth by the State, such as timely filing and procedure code validity.
- **Adherence to prior authorization requirements:** Our claims processing system enforces the supporting documentation requirements of certain designated services. In addition, this system will, when appropriate, configure a prior authorization by code, by provider type, and

by place of service. Our claim edit rules validate the claim against the network provider, member, date(s) of service, service(s) rendered, and service unit(s) authorized.

- **Provider qualifications:** We configure provider files by specialty and service category. This configuration allows for enforcement of service categories and provider type during claim validation. Certain procedures can only be performed by select network provider types. For example, our system will not permit the processing of a claim for in-office heart surgery by a podiatrist. This system also checks other providers' specific items, verifying, for example, that each provider has obtained the requisite National Provider Identifier or its equivalent, has included the identifier on all claims submissions, is registered with the State of West Virginia with a valid Medicaid identification, and is an active provider for the date(s) of service.
- **Duplicate billing logic:** Our claims processing system logic and edits determine duplication of services (e.g., same member, same date, same network provider, same service, or any combination of these criteria), and protect against payment of duplicate services.

Encounter Management System

Our encounter management system, Edifecs, is an integrated, HIPAA X12-compliant, single system for encounter management that consolidates submission and reconciliation processes to support CMS, federal, and state all-payer claims database, as well as custom encounter submissions. This system performs comprehensive encounter validation through a coordinated set of edits and validation rules that comply with state-specific business rules, enabling us to proactively identify potential data issues and correct them at the earliest stage of the reporting process. A dedicated team monitors regulatory changes in the market and performs any needed product updates to meet Department requirements and timelines. This helps to ensure accurate, consistent tracking, trending, process improvement, data collection, monitoring, validation, reporting, and error correction.

We conduct a coordinated set of edits and data checks, enabling us to proactively identify potential data issues and correct them at the earliest possible stage of the reporting process, correcting as necessary to help secure the integrity of the encounter. In addition to our internal checks, we also replicate all Department-defined encounter-editing logic to our list of data checks. This added due diligence helps us to identify encounter errors proactively. To monitor

and maintain timeliness of encounter submission, we track timeliness for both initial encounter submission and error corrections to make sure all medical encounters are submitted no later than 30 calendar days after the end of the period in which the service was paid.

Aetna transmits validated encounter data using HIPAA-compliant 837 institutional, professional, and dental formats. Edifecs provides HIPAA strategic national implementation process levels 1 through 5 edits out of the box to ensure proper formatting and all appropriate data elements are present. Validation happens at both the encounter and file level and mimics Department validation requirements even before we submit the file to the Department. Overall, these steps help us ensure that formatting and all data elements within the files are as error-free and complete as possible prior to submission, which increases the acceptance and overall completeness of the encounter data submission.

As described above, Aetna's encounter process includes steps to receive, validate, correct, monitor, and transmit encounter submissions, and is presented in **Figure 6.10.1-4.**

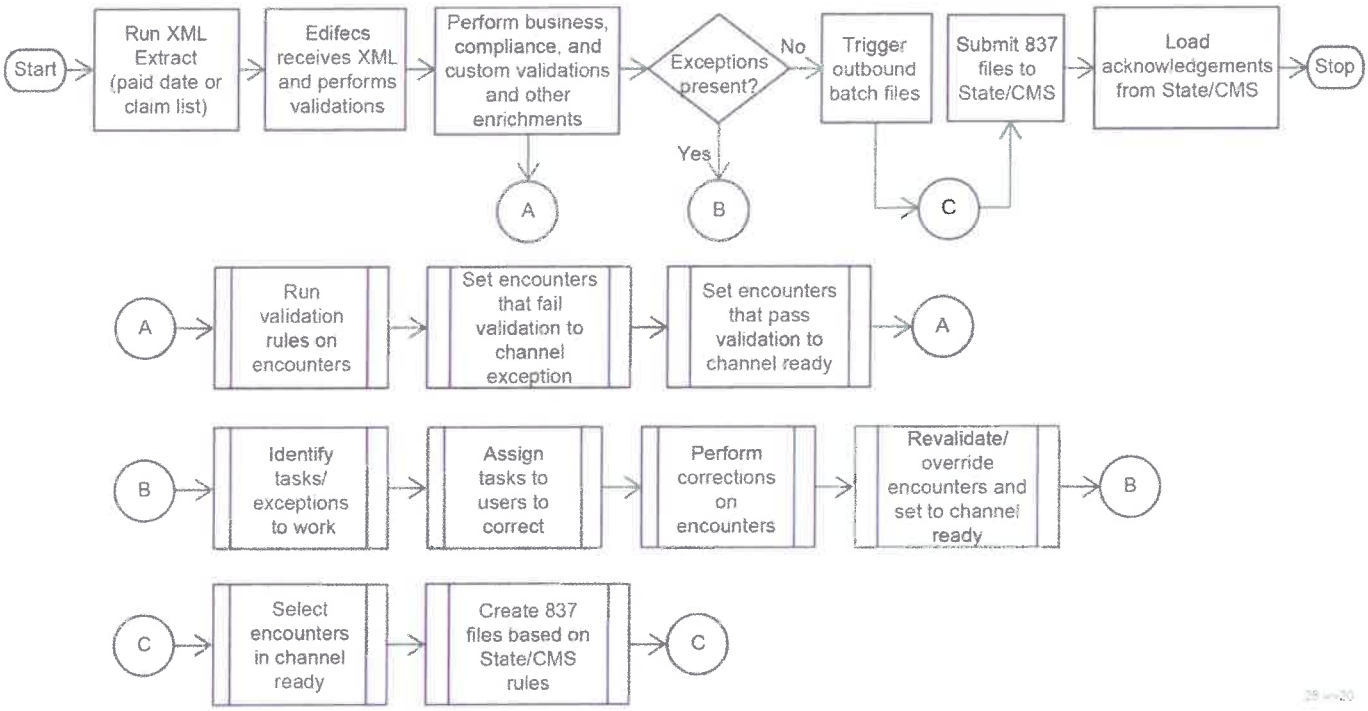


Figure 6.10.1-4: Life of an Encounter

This graphic depicts our encounter management process, which we use to proactively identify potential data issues and correct them at the earliest stage of the reporting process.

Our encounter management system also validates encounter files received from all subcontracted vendors (such as vision and dental) for compliance using standard HIPAA guidelines and strategic national implementation process levels 1 through 5. It performs multiple levels of validations including duplicate checks on the encounter information and provides comprehensive validation steps that ensure files are accurate and complete prior to submission.

The process we use to correct the claims errors depends on the errors received from the Department. Our Encounters Management Unit (EMU) prepares weekly reports of the denied inventory and assigns the work to the responsible Aetna department for review and correction. Our EMU uses two processes to manage correction activities, depending upon whether re-adjudication is necessary. If claim re-adjudication is not necessary, the EMU executes corrections to allow the resubmission of encounter errors per the Department's encounter

correction protocol. If re-adjudication is necessary, the EMU reprocesses the encounters in the appropriate claim system following the encounter correction protocol and provider recovery process if needed. These encounters are then imported back into Edifecs for resubmission if necessary. Edifecs generates, as required, the appropriate void, replacement, and/or adjustment records. To help ensure accuracy, our data correction procedures enable the team to identify and correct encounters that failed the acceptance process. We apply lessons learned to improve the accuracy of encounter submissions and to minimize rejections as part of our continuous process improvement protocol.

Experienced Encounter Staff

Under the oversight of our local Encounter Data Integrity department manager, our centralized operational EMU is responsible for data collecting, submission, and correction processing. They are subject matter experts on claims/encounter processing systems and have detailed knowledge of HIPAA files including X12 (837P, 837I, 837D); Medicaid compliance requirements; business intelligence tools; and knowledge of analytic programming tools and methods (Statistical Analysis System, Structured Query Language, Business Objects, Microsoft Office Power Business Intelligence platform, etc.). In addition, our local dedicated EMU has over 10 years of West Virginia-specific experience. Our current team, listed below, includes one manager and dedicated staff who perform the following roles:

- Project manager acts as the health plan/state encounter liaison; manages metrics/compliance and end-to-end processing from core claim system through submission to state/federal regulator; and monitors system updates, conversions, and migrations.
- Encounter technical analyst (ETA) controls data management and reconciliation of large data sets, technical business requirements, mapping documents, and state and system testing; displays intimate knowledge of electronic data interchange transaction sets; and interacts with the state's technical intermediaries and state Information Technology departments on an ongoing basis.

- Encounter validation analyst (EVA) manages data exports for submission to state/federal regulator, regulator response file imports, reconciliation of submissions, testing of support systems and workflows, and analysis for submissions accuracy and timeliness.
- Encounter correction analyst manages claims and encounter error corrections and claim/encounter data issue identification and resolution.
- Encounter report analyst supports, develops, and maintains standard reports; creates on-demand ad hoc reports; and works with EVA/ETA to monitor data, inventories, and anomalies.

Our West Virginia-dedicated team meets regularly to review encounter exceptions, rejections, denials, file tracking, and trend reports with our Encounter Data Integrity department manager. During the review process, if our Encounters department identifies any system-related issues, we work directly with our Information Technology department and other business teams to identify the root cause for quick resolution. This joint team analysis determines if adjustments need to be made to the claims which results in resubmissions, claim adjudication system, encounter editing, or encounter processing. The feedback we receive from the Department also prompts us to review our system rules and updates, as necessary. Our dedicated plan-centric team enables us to streamline decision-making, increase accountability, and reduce risk of compliance issues.

As an incumbent managed care organization, EMU and health plan contacts work directly with the Department to address encounter-related issues, questions, and review Department bulletins to address conflicts to further ensure the quality of submissions when needed.

In 2019, our Encounters team achieved a 98.9% accuracy rate and a 99.9% timeliness rate.

Aetna understands the critical role that timely, accurate, and complete encounter data plays in the Department's ability to continuously review the health care utilization of its Medicaid enrollees, to analyze expenditures associated with that utilization, and to monitor service delivery performance with its partners. Aetna has been submitting Medicaid encounter data in

West Virginia for 10 years and our national Medicaid organization has over 30 years of experience transmitting accurate, complete, and timely encounter data to Medicaid agencies. We are dedicated to our collaborative and innovative relationship with the State, enrollees, providers, and community-based organizations, to continue to create a healthier West Virginia. We support this goal through our expertise in providing accurate and timely encounter data through technology that increases service efficiency and effectiveness, which enables us to offer our enrollees additional benefit programs and/or services.

Our expertise with West Virginia encounters, paired with our superior rate of accuracy and timeliness, has helped mitigate provider administrative burden, support our enrollees, and serve the Department as a dedicated and loyal managed care organization. We are compliant with HIPAA and all other federal and state regulatory requirements.

Encounter Certification and Reporting Process

CE008	The Vendor should describe its encounter certification process that requires its Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other designee to certify the accuracy and completeness of its claims/encounter data information submitted to the Department.

Our encounter certification policy requires we comply with the West Virginia requirement that our CEO/CFO or designee attest to the accuracy, completeness, and truthfulness of encounter data. Procedurally, we validate the accuracy and integrity of our encounter data for 100 percent compliance. Our Encounter department liaison, who reports to our CEO, completes the monthly file certification process by the 15th day of each month and includes data for the previous month. Our Encounter department liaison then populates the attestation template data according to Department requirements. Our approved health plan CEO/CFO or designee then reviews this form for accuracy, and then approves and signs the form. Our Encounter

department liaison then uploads the signed form to the Department file transfer protocol for submission and a copy is also sent back to our Encounter department for tracking purposes.

Achieving Accurate and Timely Submission of Complete Encounter Data

CE009	The Vendor should describe its process that ensure complete and accurate encounter data is submitted to the Department on a monthly basis and no later than thirty calendar days after the end of the period in which the service was paid.

Our EMU monitors our submissions and the data correction process closely through Edifecs, using a series of reporting tools for both initial encounter submissions and error corrections to make sure all medical encounters are submitted no later than the 30 calendar days after the end of the period in which the service was paid.

We monitor the accuracy, timeliness, and completeness of our encounter data to make sure that we meet Department submission requirements by using a series of reports that track the following metrics:

- End-to-end financial reconciliation report tracks completeness at the encounter and financial level throughout the encounter continuum
- Weekly error reports provide detail level information by error code and aging and is used by the health plan, enrollment, vendor, and encounter staff to correct internal or external exceptions related to claim, member and provider data
- Monthly compliance reports monitor encounter timeliness and accuracy results by month of submission to ensure compliance

Additionally, all encounters that have passed through the systems internal editing, which includes HIPPA and Department-specific editing, are batched and submitted to the Department via secure file transfer protocol in the required format at least weekly, on our required submission date in order to ensure they do not exceed Department requirements.

We perform detailed encounter file reconciliation activities at both a file and encounter level throughout the submission process. These are performed for both inbound and outbound files. This validation is completed using the following series of reports:

- The status of the outbound file submission for batched encounters, the number of encounters, the status of the outbound file, and the status of the encounter with respect to different levels of acknowledgments
- The count of encounters that are accepted, rejected, or pending at different levels or tiers (999, 824, and others)
- Information regarding the percentage of accepted encounters with respect to the total number of submitted encounters

Our proactive monitoring practices ensure our data is complete and timely upon submission.

Once the files are submitted, our encounter validation analyst retrieves, analyzes, loads, and tracks State 999, the Business Rejection Report (BRR), and 824 response files, via a file tracker, to ensure all records were processed successfully. This analyst also oversees the tracking, review, and correction of rejected encounters on a first-in/first-out basis within 30 days of receipt.

We use a six sigma-based quality improvement methodology to further improve and reduce rejects, which ultimately supports timeliness. Edifecs allows management and error tracking across denial reasons, claim type, recipients, providers, claim adjudication date, and the BRR file received date.

Aetna understands the importance of submitting accurate, timely encounter data to the Department for programs, which we have demonstrated through our consistent results year-over- year for superior accuracy and timeliness. The accuracy and timeliness results summarized in **Table 6.10.1-5** below include medical, vision, and dental services.

Table 6.10.1-5: Encounter Accuracy and Timeliness

Encounter Submission Metrics	Aetna West Virginia Encounter Accuracy (%)	Aetna West Virginia Encounter Timeliness (%)
Target	95%	95%
July 2019	99.87%	99.73%
August 2019	99.83%	99.99%
September 2019	99.73%	99.92%
October 2019	99.79%	100.00%
November 2019	99.72%	99.61%
December 2019	99.80%	99.99%
12-month rolling average	99.86%	99.90%

Encounter Accuracy and Completeness Monitoring Program

CE010	The Vendor should describe its process and how they will implement a data accuracy and completeness monitoring program for its encounters that includes delegation oversight of subcontractors, as applicable.

We designed our encounter management technology solution to validate encounter files received from all subcontracted vendors (such as vision and dental) for compliance using standard HIPAA guidelines and strategic national implementation process levels 1 through 5. This system automatically performs multiple levels of validations including duplicate checks on the encounter information and provides comprehensive validation steps that ensure files are accurate and complete prior to submission. Please refer to **Figure 6.10.1-5**, which illustrates the vendor encounter submission process.

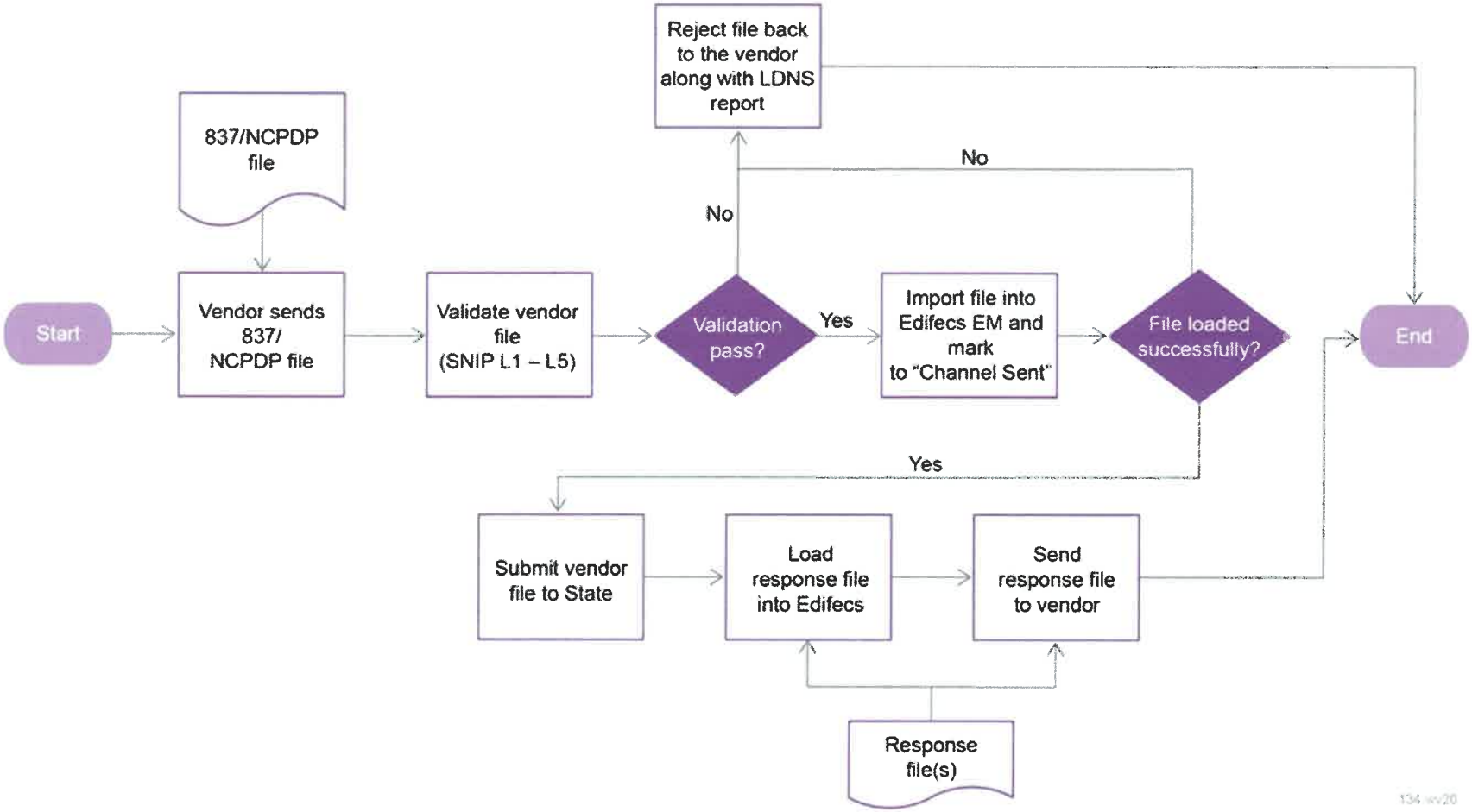


Figure 6.10.1-5: Vendor Encounter Submission Process

This figure depicts the specific encounter and validation steps we follow to ensure our files are accurate and complete prior to submission to the Department.

We administer a set of validated processes weekly to correct encounter errors we receive from the Department. Our centralized, operational EMU is responsible for data collection, submission, and correction processing. This team of claims and encounter processing system subject matter experts is knowledgeable of HIPAA requirements, State, and Medicaid compliance requirements, business intelligence tools, analytic programming tools, and our validation methods. Our EMU constantly tracks encounter errors, validates the resolution of these errors, and prepares weekly reports of the denied inventory to make sure we resolve the errors timely. The EMU meets with all subcontracted vendors regularly to review denial trends, accuracy results, and provide feedback and assistance in resolution of errors.

Subcontractor and Provider Encounter Data Submission

Timely and accurate encounter data is essential in obtaining meaningful information on members and promoting better health outcomes. Aetna actively works with and supports subcontractors and providers to address any challenges they have submitting complete, accurate, and timely data.

We initiate subcontractor training upon contract completion regarding Department billing and submission requirements. At a minimum, subcontractors meet weekly with the EMU and the health plan through the development and implementation phase. Full testing is conducted prior to production submissions to make sure all encounter requirements are being met. Post-implementation, the EMU meets regularly with the subcontractor to review denial trends, accuracy results, and provide feedback and assistance in resolution of errors.

We work with and communicate continuously with our subcontractors to promote compliance with Department requirements. To support the correction of errors, we discuss encounter and claim denials during the Joint Operating Committee meetings we conduct with subcontractors,

as well as provider groups. If subcontractors fail to submit complete, timely, and accurate encounter data, we use training, oversight, corrective action, and contractually appropriate sanctions, to address the deficiency. Our subcontractors and network providers must attest to the completeness, truthfulness, and accuracy of all claims and encounter data they submit to Aetna.

We train our subcontractors on proper encounter data submission methods, including submission frequency, acceptable data formats, accuracy, and completeness. We provide support on proper coding and present an overview of how the encounter management system enforces accuracy. We meet regularly with our vendors to ensure we address any questions and issues and to discuss error resolution. Aetna uses contractual requirements and service performance agreements to monitor provider and subcontractor compliance with all contractual responsibilities. Additionally, we train our providers during the orientation process and our local West Virginia provider services representatives provide support with the claims submission process.

Subcontractor Delegation Oversight

The EMU meets with all subcontracted vendors regularly to review denial trends, accuracy results, and provide feedback and assistance in the resolution of errors. In addition, Aetna created a delegation oversight policy that outlines how we actively monitor subcontractor performance, including non-submission of encounter data. Specifically, Aetna monitors subcontractors and providers by approving subcontractors' or providers' program operations as outlined in our quality and utilization management programs and plans. Our medical management director monitors the reports from subcontractors or providers (delegated-use

organizations) according to the delegation agreement (or contract). This medical management director then shares findings and results with our CMO.

We proactively report subcontractor or provider non-submission of encounter data to our encounter data manager, who reviews the report with the vendor oversight and relationship manager and provider services manager. Additionally, our encounter data manager prepares and delivers quarterly encounter data reports to our program manager/COO. Our vendor oversight and relationship manager and provider services manager assess the reported deficiencies and determine the best course of action. This effort includes meeting with the subcontractor or provider to determine whether the performance issue can be resolved or if escalation to the program manager/COO is necessary. If these deficiencies persist, the program manager/COO refers the matter to the appropriate committees to create a corrective action plan that includes all actions necessary to correct deficiencies. If the provider or subcontractor does not correct the problem, Aetna may impose a financial penalty or terminate the relationship in accordance with the contract.

Annual Encounter Data Accuracy and Completeness Plan

CE011	The Vendor should provide its annual encounter data accuracy and completeness plan with its bid.

Aetna's has developed and administers the following encounter data accuracy and completeness plan that includes ongoing monitoring efforts to review accuracy or integrity of the weekly encounter files and to notify the State of all identified encounter data discrepancies.

Claims/Encounters Data Policies and Procedures

Aetna contractually requires providers and subcontractors to submit clean claims to us within 365 calendar days from the date of service. This encounter data accuracy and completeness plan also includes requirements for providers to supply additional information to verify the

provider rendered covered services, the charges are usual and customary charges for such services, and the services rendered were appropriate. Our provider contracts include language referencing if the provider fails to submit claims in accordance with timely filing requirements; this failure may result in disallowance of payment and the provider must hold the member harmless. Providers must also agree to submit encounter information regarding services rendered to covered individuals when and as we request this information.

Our encounter data accuracy and completeness plan requires physicians to submit completed claims and encounter information on a CMS 1500 Form. The information to be provided includes at least the following: the covered individual's name, sex , date of birth, and Medicaid ID number; the date or dates services were rendered; CPT codes describing those services; primary and secondary ICD v10-CM diagnosis codes to the highest level of specificity; approval number for services requiring prior authorization physician's usual and customary fee for services rendered; physician's federal tax identification number; and physician's national provider identifier.

Our encounter data accuracy and completeness plan requires hospitals to submit claims for reimbursement and encounter forms on a UB-04 Form in accordance with the current Medicaid guidelines. Hospital must submit bills to us within 365 days of the date of discharge. A hospital may not bill us for inpatient covered services prior to the date of discharge and cannot separate bills for covered services for purposes of additional payments.

Weekly Submission and Review

Weekly HIPAA-compliant encounter files are submitted to Department's claims fiscal agent and its applicable subcontractors. In order to achieve the accurate and timely submission of complete encounter data, consistent with the Department's required formats, Aetna transmits all

encounter data utilizing HIPAA-compliant 837 Institutional (I), Professional (P), or Dental (D) electronic formats. Our validation begins with the delivery of services; we require all participating providers to submit all encounter services with the appropriate codes. Our QNXT system validates member data, provider data, and current coding protocol, including validation of ICD v10-CM diagnosis, CPT codes, HCPCS codes, revenue codes, modifiers, place of service, and type of bill. Secondary to our QNXT system, our encounter data management system offers further validation as well as accurately and consistently tracking encounters throughout the submission continuum, including the collection, validation, reporting, and correction of encounter data.

Monthly Submission and Review

We submit encounters to the Department on a monthly basis on or before the 15th of the month in accordance with the proprietary format requested. We deliver two text files to the State's fiscal intermediary using a secure file transfer protocol. Our business reporting team verifies data accuracy by comparing monthly claims data.

Monthly Provider/Subcontractor Review

Our Business Reporting team completes a monthly review of all encounter files, which includes a comparison of date of service to encounter submission date to ensure provider/subcontractor compliance with deadlines. We also provide a detailed report of non-compliant providers/subcontractors to Network Management and/or a vendor manager for applicable follow-up.

We resolve all identified differences with the state's contractor and the MCO through either email or phone conferences. We also notify the Department of any discrepancies or changes as a result and corrections we make to this encounter file.

Our Network Management department or our vendor manager contacts providers/subcontractors either by mail or personal visit to review issues and develop appropriate action plans to correct any deficiencies.

Encounter Activity Reporting process

CE012	The Vendor should describe its process to submit reports to the Department that summarize the encounter activity including, but not limited to, the following:
CE013	A detailed summary of the file submission that includes total claims and dollars by service category
CE014	A detailed change log that includes specifications for any change in the claims processing system that has an impact on the representation of the data in monthly encounter files

Aetna compiles and maintains, in a centralized database, encounter-level data on the services rendered by individual providers to enrollees and submits this information to the Department through a weekly HIPAA-compliant electronic data interface encounter file and a monthly Blue Box encounter file. We submit with the proprietary Blue Box encounter file a summary of providers, services, and other pertinent data to support this file. Additionally, we submit a supporting provider to assist with the analysis of said file. All relevant Blue Box encounter file items are sourced from our management information systems and reported to the Department by the 15th day of the month for claims that were adjudicated the prior month.

We not only analyze this file on a monthly basis for internal quality control but on a quarterly basis utilize the state-defined service categorization in the state-provided templates. We compare our encounter data to similar financial quarterly data, which is sourced from the Aetna Medicaid Warehouse. We report any difference between the financial data (also reported in Department-defined templates) of 5 percent to the State. We then perform a subsequent root-cause investigation of the discrepancy and initiate a resolution process to address the identified discrepancy.

[CE013] Encounter Report Summarizing Total Claims and Dollars

By the 15th of the month, we send a proprietary monthly encounter file that contains all claims adjudicated in the prior month. Additional supplemental files and data is provided with the report including a summary of total claims and dollars, a summary of providers, a newborn crosswalk, and other pertinent information that the Department can utilize in the rate setting process. These files are then sent via secure file transfer protocol to DXC along with notification that the file is ready for transmission. The CEO certifies the data and the certification form is submitted to the Department for review. At the end of the quarter, it is the responsibility of our encounter integrity manager to compare financial claims data to encounters passed to the Department during the quarter, and in doing so, report these numbers on the quarterly monitoring reports defined by the State (please refer to **Figure 6.10.1-6** for sample CEO certification letter).



STATE OF WEST VIRGINIA
MOUNTAIN HEALTH TRUST

DATA CERTIFICATION FOR MONTHLY ENCOUNTER DATA REPORT SUBMISSION

Date of Data Submission: 01/13/2020

Data Submitted By:

FOR:

Method Of Data Transmission: X Electronic Hard Copy

I hereby certify that, to my belief and to the best of my knowledge (based on all information available to me at the time such data was submitted), the data contained in the [illegible] report submission by Aetna Better Health of West Virginia was accurate, complete and truthful, and that it had no known or suspected material limitations or imperfections unless described in detail in a statement with that submission.

I further certify that I have authority to sign this certification on behalf of Aetna Better Health of West Virginia.

Certified by:

Signature

Printed Name

CEO
Title

01/13/2020
Date of Submission

aetna

Aetna Better Health® of West Virginia
500 Virginia Street, East, Suite 400
Charleston, WV 25301
PHONE: 888-348-2922
FAX: 866-810-8476

INFO BLAST

Date: October 25, 2019

To: Aetna Better Health® of West Virginia Practitioners and Providers

From: Provider Relations Department

Subject: ▶▶ PROVIDER ALERT ◀◀
Aetna Better Health® of West Virginia - *Important Information*

Pages: 2 Including Cover

We have added important information to our provider website. Visit the website at www.aetnabetterhealth.com/westvirginia/providers, click on *Document Library* on the left hand side then click on *Provider News*. The following information has been added

- 2019 Member Satisfaction Results
- 2019 Medical Record Review Results
- 2020 Important Information for Practitioners and Providers, which includes information on
  - Appointment Access Requirements
  - Utilization Management – how to contact UM, how decisions are made, and how to obtain criteria
  - Population Health and Integrated Care Management Programs
  - Who to contact for pharmacy questions
  - Member Rights & Responsibilities
  - Family Planning and Direct Access to Women's Health
  - Advanced Directives
  - Importance of Continuity and Coordination of Care
  - Clinical Practice Guidelines
  - Second Opinions, Out of Network Care, and Hours of Operation Parity
  - How to report suspected Fraud and Abuse

Your updated Provider Manual is also available on our provider website

If you do not have internet access, please contact your Provider Relations Representative for a printed copy of anything on our website

Thank you,

Provider Relations Department

Figure 6.10.1-6: Sample CEO Encounter Report Certification Letter

Aetna is committed to meeting and exceeding our contractual obligations to the Department, and we back up this commitment with validated and transparent business processes.

[CE014] Claims Processing Change Log

Our claims processing system specification changes are logged and tracked to ensure every change is completed accurately and efficiently by following our established procedures and

policies. We use a system change request to complete these system updates when new requirements and/or modifications to existing setup are made due to an amendment or modification of requirements. This includes any changes to an existing benefit, contract, or fee schedule that has not been already communicated through a previously submitted system change request. This process is managed through our change control tool and follows our change management process, which provides a structured, flexible, and fully recoverable framework in which to implement and manage system change releases on schedule and per federal, state, and contract-specific requirements. Our change management process includes the following steps in the application development process:

- Analysis
- Development
- Peer review and testing
- Approval prior to implementation into production
- Post-implementation validation to ensure all impacted production systems are functioned as designed by the change requirements

Our CSRA department is responsible for all aspects of system configuration from receipt to promotion to production. This process includes logging all submitted system change requests and issue identification form into our workflow tracking system upon receipt, as well as performing analysis of current setup and needed changes, documenting the findings and solution, routing for appropriate approvals, and completing the updates in the appropriate development environment.

Our Medicaid Program Solutions team performs validation tests to confirm the requested changes have been configured correctly. After the development build is approved, the CSRA department initiates the promotion request for the Information Technology department to promote changes to the production environment. When appropriate, CSRA department staff

runs a post-production query to identify impacted claims. The requestor is then notified that the requested changes have been completed.

When we identify impacted claims, we open a project and the claims are adjusted accordingly. We track these claim adjustments within the audit trail of our claims processing system and our monthly encounter file data will reflect the impacted claim adjustment changes.

Encounter Data Reconciliation Process

CE015	The Vendor should describe its process to reconcile encounter data submitted to the Department with the financial data that it reports on a quarterly basis, including a narrative explaining any difference of five percent (5%) or higher.

As defined in the contract reporting requirements, Aetna currently submits the encounter and financial data reconciliation report to the Department on a quarterly basis within 45 days within the end of the quarter. Data for this report is pulled 30 days after the end of the quarter from the Aetna Medicaid organization data warehouse in combination with the encounter database by our encounter liaison. We update our prior quarter data with runout transactions to the date of run report. We then research, report, and rectify any difference in the report that exceeds 5 percent within 30 days.

Since implementation of the electronic data interface encounter file process, there was only one instance in February 2017 where our encounter reconciliation outcome resulted in a difference greater than 5 percent. This issue was quickly resolved, and since that time, we have met our timeliness and accuracy performance requirements every month.

From a performance improvement perspective, our Encounters team continues to identify methods to quickly identify National Provider Identifier holds and other internal holds and report them to our encounter integrity manager for quick resolution. By performing this and other

monthly reviews of our inventory, we are able to discuss solutions and determine action items for resolving outstanding encounter errors.

11. Program Integrity

The Vendor should refer to the business specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Program Integrity (PI) as part of their bid. The Vendor's narrative response should not exceed 50 pages.

Aetna understands, acknowledges, and complies with all applicable federal and West Virginia laws and regulations including, but not limited to, state and federal fraud, waste, and abuse (FWA) regulations including West Virginia Code §9-7-1 *et seq.*, 42 C.F.R. part 455, 42 C.F.R. § 438.608, and Section 6032 of the Federal Deficit Reduction Act of 2005 and those detailed within business specifications located in Appendix 1: Detailed Specifications and pertinent narrative in Section 4: Project Specifications in this RFP. We take our role as a steward of finite Medicaid Mountain Health Trust taxpayer-funded appropriations very seriously with a commitment to identifying and preventing FWA.

Aetna has taken the stewardship role seriously as a state partner for over 23 years. We continue to elevate the awareness through staff and provider education on prevention, detection, and reporting FWA. Overall, Aetna has demonstrated successful collaboration with 16 state and federal FWA oversight agencies. In West Virginia, we routinely collaborate with other Medicaid managed care organizations (MCOs), Department of Health and Human Resources (Department) Office of Program Integrity (OPI) within the Bureau for Medical Services (BMS), the Medicaid Fraud Control Unit (MFCU) that just recently moved under the West Virginia Attorney General's office, and the U.S. Attorney's Office to detect, deter, and eradicate FWA.

At Aetna, enrollees are at the center of everything we do. Our **local, enrollee-centered approach** focuses on individuals' holistic health needs by providing access to and delivery of cost-effective health care services. We focus on practices that are inconsistent with sound fiscal

business or medical practices that result in unnecessary cost to the State's Medicaid program. **Our program integrity (PI) initiative is supported by our unique local leadership and Aetna Medicaid organization that offers 30 years of national, robust experience in 16 states.** This translates into a robust PI program that consists of written policies, procedures, practices, and standards of conduct that proactively prevent FWA.

Detailed Summary of Program Integrity Plan

PI006	The Vendor should provide its compliance plan with clear goals, timelines, assignments, and measurements as outlined by the Department.

Aetna's compliance plan is the foundation of our PI effort in accordance with state and federal requirements. Our compliance program is derived from the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG)'s Seven Elements of an Effective Compliance Program as they appear in 42 CFR § 438.608(a)(1).

Annually, Aetna, both nationally and in West Virginia, prospectively evaluates our compliance program through a risk assessment containing:

- All Medicaid-related business operational areas by types and levels of risk to Medicaid and Aetna
- External factors including information provided in OIG Annual Work Plan, external audits/reports, etc.
- Functional level risk assessment with Medicaid business partners: providers, vendors, internal audit, and subcontractors
- consideration both external and internal factors utilizing a combination of objective and normative measures

Once applied, Aetna's Medicaid Compliance Risk Assessment Tool results in high-, medium-, and low-risk priorities. Risks can include regulatory or contractual requirements and associated implementation of new programs or new technologies. The risk areas drive the prioritization, including monitoring and audit activities, of the Medicaid Compliance Work Plan. Aetna's risk assessment results are shared with Medicaid senior leadership by Compliance Lead, Alva

"Fuzzy" Page, III through the Medicaid Compliance Committee as well as business teams to ensure key areas of concern are appropriately considered and addressed.

Aetna's annual compliance plan including our FWA plan is submitted by October 1 to BMS. The FWA plan comprises all required contract elements including the following:

- Reviewing and auditing operations to guard against FWA
- Verifying services provided to enrollees
- Reviewing claims payment internal controls to ensure proper claim processing and payment
- Educating employees, network providers, and beneficiaries to identify and report FWA
- Effectively organizing resources and procedure to investigate and report FWA schemes and allegations
- Developing procedures to monitor service patterns of providers, subcontractors, and enrollees

Program Integrity Goals

Our core values of excellence and integrity promote responsibility and accountability in the delivery of high-quality, cost-effective health care. Across all of Aetna's national Medicaid managed care health plans, we collectively discuss collaborative learning and planning for the next year's activities to inform our West Virginia-specific compliance and FWA goals. Our goals include **a zero-tolerance policy toward FWA,** uncovering through the use of every available method all instance of FWA, giving close attention to evolving trends and current procedural terminology (CPT) codes or other emerging schemes and using what we have learned to emphasize prevention and reduction of FWA risks in concert with BMS and MFCU; ensuring all instances of possible FWA are referred to the BMS and MFCU promptly as prescribed by the Department. The core PI values and commitments are consistently communicated to employees beginning at their onboarding/new-hire training through a variety of means, including email communications, our website, and during town hall and departmental meetings.

Aetna's Program Integrity Mission

To protect the health and financial wellness of the people we serve by leading the fight against health care FWA as we help to build a healthier world.

Aetna ensures applicable subcontractors implement and maintain a compliance program and our processes and those of any subcontractors include internal controls, policies, and procedures to detect and prevent FWA. In accord with the OIGs seven elements of an effective compliance plan, our efforts focus on the following:

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements including state and federal regulations
- The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with contract requirements
- The establishment of a Regulatory Compliance Committee on the board of directors and at the senior management level charged with overseeing the organization's compliance program
- A system for training and education for the compliance officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract
- Effective lines of communication between the compliance officer and all employees
- Enforcement of standards through well-publicized disciplinary guidelines
- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks

Our Special Investigations unit (SIU) protocols include the routine internal monitoring and auditing of compliance risks. These protocols enable prompt response to compliance concerns, investigation of potential compliance issues as identified in the course of self-evaluation and audits, correction of such matters promptly and thoroughly (or coordination with law enforcement in instances of criminal acts) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

Compliance with Required Timelines

Throughout our collaboration as a Mountain Health Trust MCO we have demonstrated compliance and continue to promptly comply with BMS and MFCU timeline requirements in providing all required reports and information requests. We understand that extensions may be necessary to respond to an RFI. When that is the case, Aetna promptly requests an extension and responds to the request within the adjusted timeframe granted by MFCU and/or BMS OPI. Aetna submits to

BMS program integrity activities by the 15th of each month the Suspension and Adverse Enrollment Action during the prior calendar month, as noted in the contract for all in-network providers:

- Suspensions, terminations for cause, and provider credentialing denials and non-renewals for cause.
- Notification from the Department or learning that a network provider has been suspended based under § 1128(b)(8), as amended, of the Social Security Act or terminated from participation in a Medicaid program
- All providers on Federal List of Excluded Individuals or Entities (LEIE) Database

Aetna continually monitors its provider network and confirms the Department's standards are met, notifying Department of any additions or changes to the network. These required timelines are built into our FWA reports, policies, and procedures and strictly follow our compliance plan. We also understand and comply with requirements to notify BMS of program integrity staff vacancies or absences of longer than 30 calendar days.

Aetna notifies BMS of all incidents of suspected FWA including those referred to an entity other than BMS, such as licensing, prescribing authorities, and/or other disciplinary bodies. In 2019, **Aetna met the response timeline requirements of all 253 BMS/MFCU requests with only four extension requests** necessary to receive data/information outside the scope of SIU operations. Aetna has complied with the timeline for BMS suspension of a provider:

- One business day of notice by BMS, confirm receipt
- Payments suspended within 3 business days

Compliance Staff Assignments

As our compliance program describes, our compliance officer, **West Virginia native Alva "Fuzzy" Page III, Esq.,** reports to CEO Todd White and the board of directors. In her role as **program integrity lead for Aetna, Shannon White-Metz** is responsible for serving as the primary contact person for all BMS program integrity (PI) inquiries and concerns as well as

leading all PI efforts for the health plan. The responsibilities of the compliance officer include maintaining effective lines of communication with our staff by way of meetings and brown bag sessions. In addition, Mr. Page engages in open door sessions whereby West Virginia plan staff from across the organization can discuss PI and FWA concerns or any compliance-related questions. Located in Charleston, Mr. Page is the point of contact for the Department as well as internal Aetna staff regarding compliance and program integrity. Aetna currently has three full-time SIU staff dedicated to West Virginia. The PI staff identified in **Figure 6.11.1-1**, located in West Virginia, works directly with the SIU and Compliance teams regarding FWA activities and Aetna's local prevention and detection efforts. In collaboration with Compliance, this team also works with the SIU West Virginia team on timely responses to Department requests for compliance information. Our three West Virginia-based SIU investigators, with one per 60,000 or fewer enrollees, including native West Virginian Shannon White-Metz, **are 100 percent dedicated to our West Virginia enrollees,** Medicaid health plan and report directly to the health plan CEO. All company issues, suggestions, and communications are submitted to a compliance inbox and addressed accordingly.

Program Integrity staff, at a minimum, perform the following duties:

- Initiate investigations and develop FWA cases for future action
- Follow up appropriately on program integrity leads from BMS
- Execute and respond to RFIs, including the following:
  - MFCU data and documents requests
  - Execute and respond to RFIs from BMS or other state actors
- Act as the point of contact for program integrity deconfliction
- Participate in West Virginia-based training, task forces, and other relevant meetings

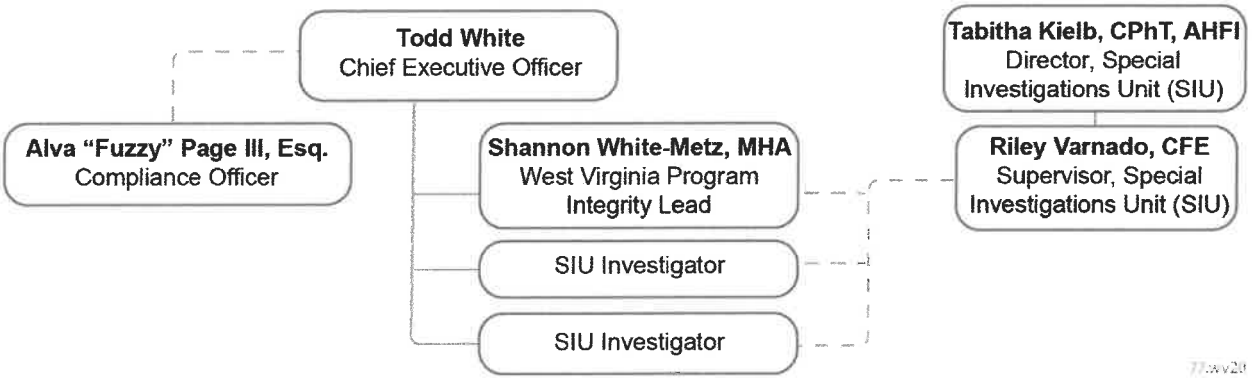


Figure 6.11.1-1: Program Integrity Organizational Chart
Our FWA reporting structure ensures responsible oversight and executive input.

The Aetna Enterprise's Board of Directors Regulatory Compliance Committee oversees plan compliance activities to ensure adherence to contractual requirements, as well as state and federal regulations. They review audit findings and other compliance efforts and report to the board. This committee is comprised of the health plan chief executive officer, chief financial officer, and two appointed board enrollees.

At the senior management level, Mr. Page chairs the Regulatory Compliance Committee, which meets at least quarterly to review trends, data mining, allegations of FWA as well as risk and risk mitigation, training (compliance and FWA), and contract compliance issues. In addition, Aetna has monthly FWA meetings to address schemes and trends, ongoing investigations, implementation of FWA prevention policies and provider education, restitution/overpayment, or contractual action. The committee is comprised of leadership from Medical Management, Quality Management, Health, Provider and Member Services, Grievance and Appeal, Pharmacy, Operations, and the SIU. The PI/SIU staff make presentations to the committee to create awareness of potential risk and further identify trends and/or prevention opportunities.

The committee may discuss potential compliance gaps and reports any instances of quality noncompliance to the Quality Management Oversight Committee.

Our PI team receives support from the Aetna Medicaid organization's national SIU team. We have **144 national full-time staff dedicated to FWA with hundreds of years of experience, including the three investigators dedicated specifically to West Virginia**. The SIU staff collaborate and share their expertise and best practices gained as FWA industry experts and across Aetna lines of business. In addition to supporting the health plan, the SIU team also identifies schemes occurring in other Medicaid plans, then can data mine for those schemes within Aetna. Working collaboratively creates synergy with our corporate investigators w improving Aetna's ability to detect and remedy incidents of FWA. For example, if a provider improperly bills Medicare, investigators check all lines of business for the same allegation, including Medicaid. Similarly, Aetna's national Medical Economics committee advises the local health plan regarding current trends and schemes occurring around the country such as identification of overbilling of urine drug screens (UDS) related to the opioid crisis.

Aetna's West Virginia UDS Industry-leading Initiative Results in Significant Cost Savings

Aetna was at the forefront of uncovering a national fraud scheme related to unnecessary urine drug screens (UDS) as part of the opioid crisis. Aetna identified large utilization spikes of both definitive and presumptive screening. Aetna's PI lead, Shannon White-Metz, after conducting a detailed analysis, presented data to the FWA committee and our chief medical officer/medical director, Dr. Donald Gibbon.

As conscientious stewards of finite state resources, we were the first to uncover this national issue. As part of the analysis we saw prior year treatment had dropped off significantly and providers focused on testing rather than treatment. Through policy development, we helped redirect providers to change their focus to treating enrollees versus testing.

Our West Virginia SIU worked in concert with Medical Management and proposed the state develop a policy to addresses UDS overutilization within the Suboxone® programs. Cost savings for one CPT code (G0483) out of the 7 codes identified in the UDS policy was over $4 million:

- **2017**: 20,675 (claims) $4,503,357.00 (paid)
- **2018**: 2,956 (claims) $587,847.00 (paid)
- **2019**: 302 (claims) $53,399.00 (paid)

After other Mountain Health Trust MCOs asked BMS for Aetna's UDS policy, they enacted a new policy based largely on Aetna's policy in July 2018, requiring all Medicaid MCOs to follow.

Measuring Program Integrity Success

We use auditing and monitoring tools such as sophisticated, market-savvy technology to measure compliance with program requirements and achieve success while we meet program goals and timelines. Aetna collaborates with RFIs that have led to provider prosecutions and recovered dollars. We typically are at the top of dollars brought back and shared with the state, partially because Aetna has more substantial enrollment of more complex care enrollees and experience higher claim volume than other MCOs.

A recent success involved our SIU investigation of a provider billing unlisted molecular pathology (CPT code 81479) often used in testing for cancer and cystic fibrosis. Through this investigation we uncovered a national fraud scheme that extended to reviews by the OIG and other national carriers. Medical records reviews by the West Virginia Chief Medical Officer/Medical Director, Donald Gibbon, DO confirmed the tests were not medically necessary. Aetna Medicaid's National Code team addressed the management of the CPT code and the SIU collected the provider overpayments.

Administrative and Management Arrangements and Procedures to Detect, Prevent, Investigate, and Report Potential FWA

PI001	The Vendor should describe its administrative and management arrangements or procedures that are designed to detect, prevent, investigate, and report potential fraud, waste, and abuse (FWA).

Our robust PI procedures are designed to reduce or neutralize the deliberate misrepresentation of need or eligibility for services; providing false information concerning costs or conditions to obtain reimbursement or certification of services that are not medical necessary; or claiming payment for a service that was never delivered or received. Our major FWA activities include the following:

- **Detection:** using proactive data analysis to identify providers, members, and staff of interest based on behaviors within their peer groups
- **Prevention:** of FWA actions from occurring in the first place and includes prepayment claim review to avoid payments and deter service payment from occurring in the first place
- **Investigation:** thoroughly exploring historical/current provider billing/practice behavior including identification of new risks and schemes, as well as potential patterns or isolated instances of FWA based on historical knowledge
- **Reporting:** operational and financial results reporting, and mandated State and federal fraud reporting related to internal and external stakeholders

Aetna uses a variety of techniques, analysis, and technologies to detect, prevent, investigate, and report questionable billing practices and avoid fraudulent claims payments, including business intelligence software to identify providers whose billing, treatment, or enrollee demographic profiles differ significantly from those of their peers.

Active Collaborative Engagement in Program Integrity

Aetna is an active and major contributor in monthly collaboration calls and quarterly meetings with other Medicaid MCOs' SIU staff to share information about fraud schemes and other relevant issues.

Aetna SIU fosters a comprehensive approach to addressing both enrollee and provider fraud by leveraging all available data sources to detect emerging fraudulent patterns. When we receive an enrollee or provider allegation and/or referral, we validate the allegation and determine if further action is required.

Detecting and Preventing Provider FWA

Aetna incorporates numerous procedures, methods, and tools to proactively detect incidents of FWA using algorithms, fraud detection software, investigations, and record reviews. Our

oversight and monitoring programs verify adherence to Aetna, state, and federal policies. We use proactive data analysis to identify providers based on behaviors and questionable billing practices and to avoid fraudulent claims payments. Aetna runs weekly reports and manually review 100 percent of all claims submitted with dollar amounts of $50,000 or more and paid amounts of $30,000 or more. Investigators review data mining reports and take appropriate action.

Aetna Prepayment Policy

Any provider identified as a possible prepayment case is reviewed with health plan senior leadership. If approved the information is sent to the Department PI, not for approval, but as information and a letter is sent to the provider. Aetna has processes in place to ensure that providers are put on prepayment review only for claims relevant to identified concerns so that other claims are not delayed unnecessarily or punitively. We monitor the providers on prepay to safeguard they do not stay on prepay for long periods of time (i.e., no 'payment purgatory').

Aetna Medical Directors, PA and UM staff review claims to determine if the provided documentation supports the billing, if billed charges are necessary and reasonable, and to identify non-covered services and supplies and inappropriate and undocumented charges. Our claim system and editing process edits for the following: member data (e.g., age, gender), provider data, current coding protocol, assistant surgeon, place of service, type of bill, medical visit logic, medical unlikeliness, DME, new-visit frequency, and professional, technical, and global services. Examples of red flags that may trigger further investigation include the following:

- Discrepancy between the submitted diagnosis and the treatment
- Claims that are resubmitted with coding changes to gain benefits
- Alterations on claim submissions
- Questions about the medical necessity of services rendered
- High volume or high percentage of dollars paid in one or two procedures
- Providers using a post office box as their service address

We incorporate our policies and procedures for credentialing including related to disciplinary action for members, providers, and staff as a deterrent to FWA. Claims system edits are designed to prevent, reduce, and detect potential FWA. These edits can include checks for the following:

- Covered services
- Duplicate claims
- Duplication of services
- Enrollee eligibility
- Invalid procedure codes
- Medically unlikely services for age or gender
- PA
- Upcoding or inappropriate bundling

Detecting and Preventing Enrollee FWA

Aetna helps our members with numerous means to protect them against identify theft, including but not limited to verification of services received. This includes our identification and flagging popular durable medical equipment (DME) back braces that were part of a telemarketing scheme that was driven by identity theft. Aetna's approach to preventing enrollee FWA is multifaceted and promotes enrollee safety and quality outcomes.

Examples of Member Fraud

- Loaning or using another person's identification card to get medical services
- Changing or forging an order or prescription, medical record, or referral form
- Selling prescription drugs or supplies obtained under health care benefits
- Providing false information when applying for benefits or services
- Using transportation services to do something other than medical services
- 'Doctor shopping' for prescriptions
- Overuse of emergency room (ER) for treatment of non-emergency conditions
- Residing in one state while using benefits for another state

Investigating FWA

Once FWA is detected, our SIU staff is responsible for the investigative process, depicted in **Figure 6.11.1-2**, and reporting to the Department. After the investigation is complete, a final report is presented to the compliance officer and the FWA Committee. The committee reviews the case and develops a CAP. If we find a credible allegation of fraud (CAF) at any point in the

process, the case is reported to the Department. For each allegation that warrants full investigation, the investigation is conducted in accordance with 42 C.F.R. §455.15 and §455.16.

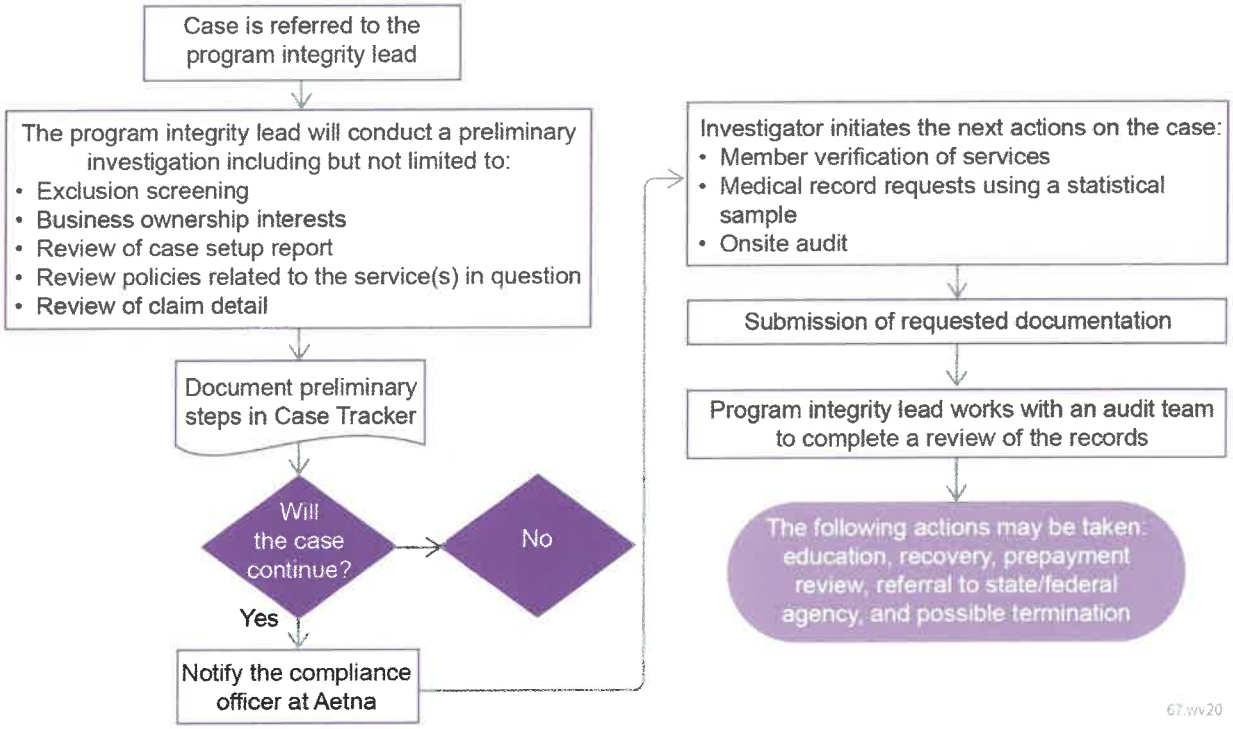


Figure 6.11.1-2: Program Integrity Process Flow
Aetna's program integrity lead plays a key role in investigating health care FWA.

Reporting FWA

All new employees receive initial CVS Health FWA training within their onboarding experience, which also includes extensive coverage of FWA prevention, detection, monitoring, and investigation details. The new employee and subsequent annual FWA training highlight Stark Law and anti-kickback requirements.

Aetna has a variety of tools designed to identify and prevent and FWA, including the following:

- A dedicated toll-free 24-hour telephone hotline, CVS Health Ethics Line, accessible to any stakeholder (including staff, enrollees, and providers) for making confidential, anonymous, and non-retaliatory verbal reports of actual or suspected FWA
- An email address and web form for enrollees and providers to report FWA
- Easy internal online access for staff to report FWA concerns confidentially to the SIU

- Information on the intranet for staff about how to report concerns to the U.S. Department of Health and Human Services, OIG, MFCUs, or other regulatory agencies

Special Investigations Unit Policies and Procedures

PI002	The Vendor should describe its Special Investigations Unit (SIU) policies and procedures for identifying and investigating potentially or suspected fraudulent behavior, and its criteria for referring such behavior to the Department.

Aetna staff provides reports of, suspected FWA by enrollees, staff, subcontractors, providers, and others business entities through monthly reporting:

- FWA report, including overpayments recovery
- Provider suspension and adverse enrollment actions
- Quarterly data mining report for detection

2019 West Virginia Program Integrity Results
QNXT cost avoidance savings: **$27,691,462**

Fraud Referral Criteria

Aetna SIU investigators refer to the West Virginia BMS-PI Department credible allegations of fraud with substantial supporting evidence validating the provider fraud. If the investigator has an allegation they cannot validate, yet details of the allegation are substantial, they refer the allegation to the Department. Referral processes are set forth within our FWA training for all new Aetna staff as well as within policy and procedure 3000.40: Deficit Reduction Act and False Claims Act Compliance Requirements.

SIU Processes

All SIU referrals are put into the case tracking system as depicted in our SIU process flow **Figure 6.11.1-2**. Our SIU processes are defined in 37 desktop procedures and 24 SIU policies and procedure documents. These begin with the SIU Overview and Case Set Up documents and conclude with our Case Referral and Collection of Overpayments procedures.

SIU Investigative Tools

Our rules-based claims adjudication system QNXT maintains and processes health care administration data, providing increased efficiency. The provider module contains a 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 the claim, and the date of payment, including the check number. QNXT scrubs/edits data for accuracy during claims processing and payment. The Aetna national Medicaid organization's Claim Quality Control department independently assesses the effectiveness of the Medicaid claims system configuration and claim procedures against the resulting adjudication process.

Aetna's 2019 program integrity efforts included the following:

- Timely filing based on state and provider contractual rules
- Eligibility denials
- ClaimCheck: a coding audit and editing system that is fully integrated with QNXT
- Authorization requirements
- Front-end claim line denials: specific lines of service that were denied during claim processing due to health plan coverage and or claims processing rules
- Front-end claim denials: whole claim denials during claims processing due to health plan coverage and/or claims processing rules
- Cotiviti claim denials: claims sent to Cotiviti for coding audit and editing pre-payment

Our claims system has edits that deny claims for duplicate claims, unknown services, unknown members, members ineligible to receive services, improper coding, and providers not eligible to provide services. During post-processing review of claims, we produce reports that show overlapping dates of service to determine if any claims have been submitted and were adjudicated for services that did not fail the claim edit logic. To prevent improper payments, we implemented the National Correct Coding Initiative (NCCI) edits as part of claim pre-payment reviews. The provider contract helps determine which of the claim edits to apply. During the pre-payment claims review, we use NCCI edits to evaluate billing of CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes listed on claims submitted by Medicaid providers. Use of NCCI edits decreases the number of overpayments as well as FWA.

The QNXT data (and legacy claims payment data) used by Aetna's SIU through the Universal Web Information Directory (UWID) system. UWID is a decision support and reporting system that authorized Aetna SIU staff uses. There are 45 unique static reports across enrollee, provider, pharmacy, and dental data. In 2019, we ran more than 4,500 reports in the UWID system.

Data Analytics to Identify FWA

The data analytics of all Aetna plans are shared between the plans (commercial, federal, Medicare, Medicaid, et al) to leverage the information on common providers and provider types.

This information sharing leads to cost reductions for analytics and in the process of 'pay-and-chase' methods of recoveries. Aetna's SIU analytics group 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. The SIU performs ongoing reviews of the plan to identify high-dollar specialties, high utilization providers, and procedures codes. These ongoing reviews suggest to the SIU investigators which specialties/providers/codes to review for outlier behavior, which is indicative of FWA.

In addition, quarterly, the SIU analytics group runs a minimum of 25 outlier reports of known categories of fraudulent schemes, such as up-coding, double billing, and billing for services that were not provided, based on specialty and CPT codes to identify the top providers of certain services. For example, services related to ER usage by high utilizers, home health, and DME are at high risk for fraudulent behavior and are included in the quarterly report presented to the plan investigators. At data mining meetings, SIU staff, the SIU medical director, and certified procedural coders discuss and prioritize data mining studies to better analyze trends and schemes identified through various sources. These sources provide information which factors

into future updates of the compliance plan and operational procedures, as well as updated and new algorithms. SIU investigators review the data mining report and take appropriate action.

Aetna's SIU also receives and uses leads provided by the Aetna Enterprise Analytics Fraud team. Our data analytics system provides efficient and proactive discovery of new fraudulent schemes, allowing for near real-time prepayment review capabilities to flag suspicious claims prior to adjudication.

Aetna enhances our SIU data mining efforts with Health Care Fraud Shield (HCFS), a customizable (at the health plan level) platform, applicable for both pre- and post-pay, that comes equipped with approximately 600 health care business rules and algorithms maintained and updated quarterly. HCFS identifies providers with potential FWA behaviors and assigns risk scores. Aetna's SIU use the HCFS screens to visualize all FWA leads and provider billing activity as well as download the past 24 months' worth of claims. Aetna's SIU can further avoid inappropriate billing, identifies, and mitigates potential provider abrasion, and deters criminal activities by utilizing key FWA concepts. Current HCFS customers report returns from $3 to $10 for every dollar invested. Aetna completed a proof-of-concept analysis of the system in 2018, and based on those results, anticipates even greater increased FWA savings, recoveries, and prevented losses.

Collaborate with Government Agencies to Administer Effective FWA Detection and Prevention Practices

PI003	The Vendor should describe its process to work with the Department, the Medicaid Fraud Control Unit (MFCU), the Centers for Medicare & Medicaid Services (CMS), and the Department of Health and Human Services (DHHS), to administer effective fraud, waste, and abuse (FWA) detection and prevention practices.

Aetna regularly collaborates with state and federal entities to support effective prevention, detection, monitoring, investigation, and reporting of suspected FWA. We have found routine

and effective collaboration and robust relationships with state and federal regulatory entities is key to proactively curb FWA. These collaborations are a tremendous asset in effectively limiting FWA in our role as guardian of finite Medicaid dollars.

Aetna has longstanding collaborative relationships with the five bureaus within the Department gained over our more than 23-year tenure as a West Virginia-contracted MCO. We cooperate fully with the Department when requested and engage as directed, including with sister agencies of BMS, to effectively investigate and collaborate on Department issues. Aetna has established unique collaborations and solutions to improve the health and well-being of enrollees throughout the state through relationships with the following organizations:

- Bureau for Behavioral Health
- Bureau for Child Support Enforcement
- Bureau of Children and Families
- Bureau for Medical Services
- Bureau of Public Health
- West Virginia Children's Health Insurance Agency (WVCHIP)

SIU and BMS Investigative Collaboration

Aetna cooperates and assists BMS or any state or federal agency charged with identifying, investigating, sanctioning, or prosecuting suspected FWA. We investigate possible acts of FWA for all services, including those that we subcontract to outside entities. If we identify that FWA has occurred in the Medicaid program, based on information, data, or facts, we immediately notify the BMS OPI following the completion of ordinary due diligence regarding a suspected fraud or abuse case. If BMS OPI accepts the case for state investigation, we engage in investigation efforts other than coordination efforts with BMS. We understand BMS OPI must supply a notice to us of the case acceptance status no later than the tenth business day after we notify the BMS OPI of the suspected fraud or abuse. We understand we may proceed with the investigation or payment recovery efforts if we receive a notice from the BMS OPI and/or the

MFCU indicating that we are authorized to proceed with a case. Notification that MFCU does not accept the referral signifies authorization for Aetna to proceed with the case. If we have not received a response from OPI after 3 requests by us or within 45 calendar days of submission of referral, we may proceed with its investigation up to and including recoveries. As a collaborative partner for over 23 years, We have routinely assisted the Department in complying with federal audits when requested.

Collaboration with the Department and Medicaid Fraud Control Unit

In accordance with 42 CFR § 438.608(a)(7), Aetna's Program Integrity Lead, Shannon White-Metz, reports to the Department and any appropriate legal authorities any evidence indicating possible FWA by a participating or non-participating provider by referral to MFCU from BMS. Aetna assists BMS and MFCU with identifying, investigating, sanctioning, or prosecuting suspected FWA. We investigate possible acts of FWA for all services, including those that we subcontract to outside entities. If we identify that FWA has occurred in the Medicaid program, based on information, data, or facts, we immediately notify the BMS OPI following the completion of ordinary due diligence regarding a suspected fraud or abuse case. If BMS OPI accepts the case for state investigation, we engage in investigation efforts other than coordination efforts with BMS. We understand BMS OPI must supply a notice to us of the case acceptance status no later than the tenth business day after we notify the BMS OPI of the suspected fraud or abuse. We understand we may proceed with the investigation or payment recovery efforts if we receive a notice from the BMS OPI and/or the MFCU indicating that we are authorized to proceed with a case. Notification that MFCU does not accept the referral signifies authorization for Aetna to proceed with the case. If we have not received a response from OPI

after 3 requests by us or within 45 calendar days of submission of referral, we may proceed with its investigation up to and including recoveries.

If we establish a credible allegation of fraud and or scheme exists, we refer it for review by MFCU and the Department's PI unit. The MFCU chief auditor and chief investigator evaluate the allegation for possible referral to local law enforcement. We use the prescribed reporting form with an evidence package, which complies with CMS required elements for fraud reporting. A credible allegation of fraud (CAF) is established through the SIU investigation and allegation analysis. Before acting, we send the CAF to BMS for evaluation of sanctions and to MFCU to determine if a criminal investigation is warranted.

Aetna routinely assisted the Department in complying with federal audits when requested.

As required, we provide documentation or information upon request to BMS, MFCU, CMS, and its contractors, or HHS OIG, related to any aspect of the contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables.

Our compliance officer, program integrity lead, and other Aetna staff and SIU leadership as needed, meet monthly with the Office of Program Integrity and the West Virginia's Attorney General MFCU whenever requested, to discuss the monthly PI-related reports, FWA, or overpayments in accord with state requirements. After an FWA investigation is complete, a final report including an executive summary, case notes, and recommendations, including any recovery figure, is presented to the compliance officer and the FWA Committee, when appropriate. This committee reviews the case and develops a CAP.

REQUEST FOR PROPOSAL

Department for Health and Human Resources
CRFP 0511 BMS2000000002

Collaboration with BMS Results in Newborn Hearing Screenings Initiative

Newborn hearing screens are required and if not performed in the hospital, pediatricians will routinely perform the screen as part of the baby's first office visit.

SIU has investigated several cases regarding providers unbundling the newborn hearing screening for separate reimbursement. The providers were all identified by billing CPT code 92586 within 1 to 5 days of the infant's date of birth during an inpatient stay billed with place of service 21. SIU found the claims were being submitted for a professional service under a licensed physician's name, when in fact, a technician performed the service.

All screenings were performed during routine newborn service (which is covered under the hospital per diem, annual percentage rate, diagnosis-related group). No professional component is required; it is limited when billed with CPT 92586.

West Virginia's SIU recommended a system enhancement to identify this unbundled coding, **resulting in savings for all Aetna Medicaid health plans of ($848,477) and $41,438 for West Virginia Medicaid.**

Collaboration with WVCHIP

As we currently interact with other bureaus within the Department and other state agencies, we will also work with Children's Health Insurance Program to address any concerns within our role as protective stewards of finite Medicaid funds related to potential FWA.

Collaboration with the Centers for Medicare & Medicaid Services and other National and Federal Entities

We stay current on FWA trends, schemes and regulatory changes through CMS fraud alerts and related articles/presentations, trainings, and forums and by participating with the CMS Healthcare Fraud Prevention Partnership and the NHCAA, for which Aetna is a founding member. Regular review of the OIG TIPs report. We also participate in the National Association for Medicaid Program Integrity and multiple health care anti-fraud task forces at state and federal levels.

Aetna is a founding member of the National Health Care Anti-Fraud Association. Senior Director of Special Investigations Richard Statchen has served on the board since January 2019.

In support of FWA monitoring, our Provider Services department verifies provider eligibility by checking providers against sources such as the West Virginia licensing board, Drug

Enforcement Administration (DEA) Clinical Laboratory Improvement Amendments, Death Master File from Social Security, and CMS National Plan and Provider Enumeration System, as well as the National Practitioners Data Bank, OIG LEIE, and the System of Award Management, on a monthly basis. The Compliance department sends these lists to the SIU and plan-level Credentialing department. If a provider appears on one of these lists, the Provider Services and Member Services departments collaborate to remove the provider and reassign the enrollee.

Maximizing Aetna FWA Resources

PI004	The Vendor should describe how they will maximize resources for fraud, waste and abuse (FWA) issues.

Each Aetna employee has a role to play in preventing and detecting FWA, as we take our role as stewards of finite West Virginia Medicaid resources seriously. Our program integrity program design and infrastructure leverage national resources and expertise within Aetna, including our 15 other affiliate Medicaid health plans as well as internal departments such as Utilization Management and Quality Management, to maximize efforts to locate FWA wherever it exists. Our PI team, including Program Integrity Lead Shannon White Metz and Compliance Officer Alva "Fuzzy" Page III, Esq., exhaustively review internal processes, maximizing our expert staff and resources as we collaborate with BMS, to develop protocols for our internal staff to best participate in FWA prevention and detection processes. In this spirit, each employee—including CEO Todd White and Chief Medical Officer/Medical Director Dr. Donald Gibbon, to clinicians, SIU investigators, and Member Services representatives—has a vital role in detecting possible FWA by fellow employees, subcontractors, and enrollees alike. Behavioral Health Medical Director Frank Angotti III, MD and Dr. Gibbon are working with BMS to develop a system of quality medication-assisted treatment (MAT) providers, addressing waste and abuse, and developing innovative approaches to the management of the complications from substance use

disorder. Dr. Gibbon also leads the Aetna Medicaid organization's national opioid task force where the Suboxone initiative was spearheaded in the development of the West Virginia policy.

Collaboration across departments maximizes FWA processes: Our Prepaid Claims and Medical Management teams also play important FWA prevention roles. Our Medical Management team prevents unnecessary waste through comprehensive reviews of PA requests, reviewing requests to make certain services occur in the right amount, time, and setting and by the most appropriate practitioner. With these processes, we make certain we elevate the strengths and skills of each employee to serve our enrollees in the most efficient and effective way possible supporting the best possible quality outcomes. We maximize all West Virginia employees, including PA reviews for overutilization and waste to create greater efficiency in services to enrollees. Our Utilization Management team assists in reducing abuse and waste through consistently reviewing claims via a prepay analysis with PA and admissions reviews. We make certain every employee is aware of the importance of detecting and preventing FWA and thus integrate PI into the design of operational (including staffing responsibilities) and system functions. The Provider Services department verifies provider eligibility by checking providers against numerous databases including but not limited to the West Virginia licensing board, DEA Clinical Laboratory Improvement Amendments, CMS National Plan and Provider Enumeration System OIG LEIE, and the System of Award Management, on a monthly basis. The Compliance department sends these lists to the SIU and plan-level Credentialing department.

Iterative testing: Aetna works to make certain the reliability and consistency of processes in the detection, investigation, and prevention of FWA assure validity within our program/payment

integrity and compliance activities. Detection, investigation, and prevention methods are checked against CMS, DEA, Federal Bureau of Investigation, OIG, National MFCU, Medicaid MCOs, and other insurance industry standards to assure methodology progresses clearly and consistently ahead of our peer group while remaining valid, defensible, and reliable. Our iterative testing process allows for identification and investigation of new schemes that can turn detection processes proactively into prevention efforts. Our relationships with national vendors and subtractors including QNXT, Cotiviti, and Equian (credit balance audit vendor) assure consistency to our strict iterative process in our allegation and scheme review protocols.

Working Together to Prevent and Detect FWA

Each of our departments plays a vital role in our compliance efforts, including promoting program integrity and monitoring for FWA. Armed with the knowledge they gain through compliance training, Aetna team members in every department have a role in promoting program integrity and monitoring for FWA. Their expertise within their disciplines, along with provider and enrollee referrals, complement the automated pre- and post-payment edits, audits, and analytics. For example, reports by our Medical Management team sometimes highlight unusual patterns that indicate potential FWA. The director of pharmacy and the director of clinical health services play roles in detecting polypharmacy and overprescribing issues. Our Provider Services and Quality Management teams are trained to identify FWA indicators during routine office visits. The Enrollee Services department tracks and documents enrollee complaints and survey results that may suggest FWA schemes or emerging trends.

Additionally, our Credentialing department validates provider credentials and evaluates provider information from a variety of sources, including federal and state licensing, quality, and exclusions databases. Aetna's West Virginia staff is highly aware of who our investigators who are here at the health plan. They reach out when concerns of FWA occur to discuss if a case needs to be referred to the Department. There is a daily Department compliance call at which representatives from each department attend and discuss any issues.

Responding to all Program Integrity and MFCU Requests

PI005	The Vendor should describe its process for responding to all program integrity and Medicaid Fraud Control Unit (MFCU) requests within the timeframes established by the Department.

Aetna routinely collaborates with MFCU through RFIs to the compliance officer and PI lead to meet established timelines and data reporting and is also copied to BMS by Aetna Compliance Officer Alva "Fuzzy" Page III, Esq., and Program Integrity Lead Shannon White-Metz. Aetna collaborates with MFCU regarding FWA investigations and CAPs, as necessary. If an Aetna investigation finds credible fraud, we report the case to BMS and MFCU.

When we receive a request for information, we process the request immediately and provide appropriate claims data; if claims data points toward validating the allegation, we submit a fraud referral to the requester. If action is required, it is sent to BMS immediately for evaluation of sanctions and to MFCU to determine whether to pursue a criminal investigation. Once workflows are established, reviewed, and approved, our program integrity lead sends the provider fraud referral information to the Department's PI and MFCU chief auditor and chief investigator for evaluation and local law enforcement review.

We designate one primary and one secondary contact person for all BMS program integrity and MFCU requests for data, records, or other information. BMS or MFCU records requests are sent to our designated contact person(s) in writing via email, fax, or regular mail and provide the specifics of the information being requested. Aetna continues to respond to the appropriate BMS or MFCU staff member within 14 calendar days or within the timeframe designated in the request. If we are unable to provide all of the requested information within the designated timeframe, we understand we are required to request an extension in writing no less than two business days prior to the due date and we make certain the data, records, or information is provided in the order and format requested. **Our collaboration with MFCU has resulted in the largest amount of recoveries in 2018 and 2019 of any West Virginia MCO. In 2018,**

resulting from a prosecuted dental provider, Aetna directly recovered over $270,000.

Aetna received a settlement of $870,000 recovery with a Suboxone clinic driven by Aetna data delivered to MFCU in 2019, resulting directly from our MFCU. Aetna was approximately 30 percent of the recoveries between four Medicaid MCOs and fee-for-service providers.

Collaboration with MFCU Results in Provider Prosecution

Dr. Antoine Skaff, a Charleston dentist, fraudulently billed[1] West Virginia Medicaid and Medicaid MCOs for dental procedures that he did not actually perform on Medicaid recipients and is now serving a five-year federal prison term.

Dr. Skaff admitted he falsely inflated his billings, a practice commonly known as upcoding, often by falsely claiming reimbursement for procedures involving impacted teeth. Typically, only wisdom teeth are impacted. Dr. Skaff up-coded billings for tooth extractions by falsely informing Medicaid and its MCOs that he performed more complex procedures, such as extractions of impacted teeth, when he had actually performed simple extractions. Dr. Skaff also up-coded at least 7,490 tooth extractions, billing more than $600,000 than necessary.

FWA Training on State and Federal Standards and Contract Requirements

PI007	The Vendor should describe its training and education of the compliance officer and the organization's employees, including senior management, on State and federal standards and contract requirements.

We encourage collaboration, cross-training, and the exchange of best practices among all our staff. Our staff training supports our internal fraud prevention. Training is a key component to our prevention and detection. We deliver effective training programs and awareness initiatives to staff, subcontractors, enrollees, caregivers, and providers through a variety of forums. Our compliance officer and all employees are trained on state and federal standards and contract requirements. The annual required training of each Aetna and CVS employee includes FWA training as well as anti-kickback requirements.

[1] "Charleston Dentist Sentenced to Five Years in Federal Prison for Health Care Fraud," Press Release of the U.S. Department of Justice: accessed January 21, 2020; https://www.justice.gov/usao-sdwv/pr/charleston-dentist-sentenced-five-years-federal-prison-health-care-fraud

Specifically, our compliance officer receives training beginning at orientation, which is conducted with the guidance of Aetna's senior director of compliance. Compliance officer orientation generally begins with reviewing the contract, as well as studying state-specific laws, regulations, and policies. The senior director is a coach and mentor, instructing the plan compliance officer about the importance of building relationships with state regulators and how law and policy changes affect the health plan, etc. The compliance officer develops a comprehensive must-shall document outlining all state contract requirements as a tool for staff members.

Senior management program integrity training focuses on results, management, and monitoring, in addition to state-specific laws, regulations, and policies. Managers and supervisors are in a unique position to influence staff members' behavior and raise awareness about compliance and ethics. Executive-level leaders facilitate quarterly compliance and ethics discussions with employees to reinforce annual compliance training. Aetna's Compliance and Regulatory Affairs website provides an extensive video and resource library for facilitating these discussions. The materials and the discussions they prompt are highly effective learning tools that promote Aetna's values and strengthen the culture of compliance.

Aetna FWA Staff Training

Training begins on the first day of employment and continues with Aetna's yearly education and training. This annual education includes all our FWA and PI policies, our Code of Conduct, and ethics via a combination of in-person and online training modules. New employee trainings include the following:

- Credentialing of providers
- FWA mission and purpose; definitions and explanations of FWA
- High-level overview of applicable federal and state regulations (such as the False Claims Act and anti-kickback regulations)
- Identification of potential fraud cases

- How staff can report FWA to Compliance and FWA investigators
- Methods of identifying enrollee, employee, provider, or subcontractor FWA
- Actions of investigations (such as data mining, claims analysis, and medical record reviews)
- Examples of successful FWA investigations
- Overview of FWA partners (such as state MFCUs, the NHCAA, and CMS)
- Specific program integrity procedures and policies tailored to individuals' department and function in their day to day duties

It is mandatory that Aetna personnel attend annual training and education sessions on Aetna's compliance program and federal and state laws and regulations (including the Health Insurance Portability and Accountability Act and FWA prevention and identification). Aetna personnel may address questions, seek interpretation and clarification, or obtain additional compliance related material from the Aetna Compliance department.

Our West Virginia compliance annual training and policies help ensure that all staff conduct business in a legal and ethical manner and to prevent, detect, and investigate embezzlement, internal theft, and other forms of staff fraud in addition to provider and enrollee FWA. All new Aetna West Virginia staff must complete this training within 30 days of hire. Upon completion of initial and ongoing compliance training, our team members acknowledge that they participated and understood the information we provided and continue adhering to compliance program requirements. **Our compliance officer, Program Integrity/SIU investigators, and other essential personnel receive specialized and mandatory trainings** on the investigative process; key West Virginia and federal regulations, processes, and procedures for addressing suspicious claims; and the procedure for facilitating communication among the health plan, appropriate authorities, and the Department. Our in-person and web-based NHCAA- and industry-specific training includes coding clinics, fraud schemes in the behavioral health arena, medical record review strategies, prescription drug fraud schemes, and intensive outpatient therapy, among others. Our compliance officer and PI team conduct ongoing FWA training at

staff town halls, departmental meetings, monthly newsletters, and upon request. We also participate in all state trainings and meetings.

Aetna publishes our **Code of Conduct training** on the intranet and on the Compliance and Regulatory Affairs homepage. All staff are required to complete an attestation acknowledging that they understand and comply with PI and compliance standards upon hire and annually as a component of their required compliance training. As set forth in our Code of Conduct, all business lines are conducted based on the highest ethical standards and in strict compliance with applicable federal and state laws and regulations. Our Code of Conduct explains to all staff that disciplinary action will be taken, up to and including but not limited to termination.

We also reinforce that each staff member must report any suspected violations of the Code of Conduct to their immediate supervisor, an Aetna compliance officer, or the CVS Health Ethics Line, which supports anonymous reporting via toll-free phone call, email, or written letter.

Aetna's extensive FWA training program begins with our senior leadership team and includes all senior management, employees, and subcontractors. Our subcontractor compliance program includes a system for training and education of the CEO, chief financial officer, the organization's senior management, and its employees.

Provider FWA Training

Because FWA detection and prevention methods often uncover patterns of provider error and confusion, we conduct annual provider training. Our Provider Services department disseminates information about FWA training to providers via fax blasts and emails each year and collects the providers' signed attestations for themselves and their staff. We provide this information to BMS during the annual compliance program review process and in the board report. The Provider

Services department also conducts provider forums every year and the SIU team participates in these forums to give providers information about trends, FWA training, and other information to increase their knowledge and reduce abuse across West Virginia.

Initial provider training takes place during orientation, with ongoing/supplemental training occurring through provider forums, our secure online provider portal (where content is available 24/7/365), the provider handbook, and through individual communications with the Provider Services team. We encourage providers to request individual supplemental training via our Provider Services staff any time they need additional information. Provider training includes definitions of FWA, provider PI and compliance responsibilities, methods for preventing FWA, and methods to report potential issues. Training also includes applicable laws such as the False Claims Act, Anti-Kick Back Statute, Stark Law, OIG LEIEs, and those enforced by the General Services Administration. If providers have audit findings of potential FWA, we also provide FWA training to prevent further occurrences.

Self-audit Training Results in Substantial Cost Savings

Interim HealthCare of Pittsburgh appeared on our third-quarter data mining quarterly report as an outlier for billing HCPCS code S9122, S9123, and S9124 with over $700,000 in applicable claims for West Virginia enrollees. Our SIU investigator had built a good relationship with the provider's management and recommended a self-audit. The self-audit performed by Interim HealthCare of Pittsburgh resulted in 108 lines (error rate of 5%) denied with overpayment identified of $38,432. Provider education resulted in appropriate billing moving forward.

Provider Self-auditing Training and Assistance

Within Aetna's participation in Mountain Health Trust, there is a provision for provider self-audit. As part of the provider self-audits The PI/SIU staff directs appropriate timeframes and specific HCPCS codes for review, follows appropriate clinical guidelines identified by Aetna's clinical policy bulletin(s), and reviews any plan of care documents and guidelines or other supportive

documentation. The HHS-OIG self-audit compliance criteria further suggests voluntarily conducting an initial, or baseline, audit examining three months of claims services followed by at least annual monitoring.

Disciplinary Guidelines and Procedures for Enforcement of Compliance Standards

PI008	The Vendor should describe its disciplinary guidelines and procedures for enforcement of compliance standards.

Our West Virginia-based SIU team members diligently safeguard against the potential for suspected FWA by staff, subcontractors, providers, and others with whom we do business and promptly investigate any allegation. Aetna provides annual training and written materials on the compliance program to all staff, providers, and subcontractors. Our web-based training details Aetna's compliance policies, programs, disciplinary standards, and operational guidelines, as well as state-specific rules and regulations including reporting suspected or known fraud and abuse, and disciplinary guidelines for compliance violations and failure to report.

Internal Disciplinary Guidelines and Procedures

In cases of employee fraud, SIU staff alerts the appropriate department and investigations occur under the direction of the Investigative Services within Aetna's Legal department. Aetna publishes disciplinary guidelines and standards and our Code of Conduct on the intranet and on the Compliance and Regulatory Affairs homepage to make certain we comply with contractual and regulatory standards. We rely on these as standards and major deterrents for FWA as they outline FWA consequences. As set forth in our Code of Conduct, all business lines are conducted based on the highest ethical standards and in strict compliance with applicable federal and state laws and regulations. Our Code of Conduct explains to all staff disciplinary action will be taken, up to and including but not limited to termination, for the following:

- Failing to follow the Code of Conduct, other policies, or breaking any laws or regulations
- Telling staff 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
- Retaliating against a staff member 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 an Aetna staff member manages and can lead to CAPs by a department or staff member

We require all employees to sign an attestation acknowledging that they understand and comply with program integrity and compliance standards upon hire and annually as a component of their required compliance training. We apply fair and consistent discipline for compliance violations. Aetna annually provides written materials about the compliance program to our providers and subcontractors, such as ways to report suspected or known fraud and abuse and disciplinary guidelines for compliance violations and failure to report.

Aetna employs disciplinary guidelines for corrective actions to improve internal procedures for program-related activities when they become non-compliant with contractual or regulatory requirements. When this occurs, it is the responsibility of the assigned director, manager, or supervisor of the department, functional area, or affiliate to act and implement the CAP. Resolution of deficiencies are not to complete until the director, manager, or supervisor of the department, functional area, or affiliate and Aetna compliance officer determines that the corrective actions implemented resulted in a correction of the deficiencies. The director, manager, or supervisor must conduct a close-out review to document that compliance deficiencies were corrected and report the results to the Aetna Compliance department.

Provider Disciplinary Guidelines and Procedures

After potential fraud is identified, we place providers on prepayment review leading to withholding of claims payment. Once potential FWA is detected, our SIU staff is responsible for the investigative

process and reporting to the Department. The FWA Committee reviews the case and develops a CAP. If it is determined there is a credible allegation of fraud, we report the case to the Department by way of referral. In many cases, the state forwards a recommendation to MFCU, which then provides direction to Aetna on how to proceed regarding overpayments or other provider action. When allegations of FWA arise during credentialing processes or other instances where we enforce compliance standards, we take a comprehensive, fact-finding approach collaborating with other departments to gain a full picture of the allegation and how to proceed. Our Credentialing department works closely with our PI team and collaborates when concerns of FWA occur to discuss if a case needs referral to the Department. The Aetna Credentialing team validates provider credentials and evaluates provider information from a variety of sources, including federal and state licensing, quality, and exclusions databases; if FWA concerns arise within their review, staff can reach out directly to SIU investigators and/or the compliance officer.

Routine Internal Monitoring, Auditing, and Remediation of Compliance Risks

PI009	The Vendor should describe its procedures for routine internal monitoring, auditing, and remediation of compliance risks and identified issues.

Aetna routinely monitors and audits enrollee, provider, and compliance risks using a variety of technologies and methods to prevent and detect questionable billing practices and to avoid fraudulent claims payments such as business intelligence software to identify providers whose billing, treatment, or patient demographic profiles differ significantly from those of their peers.

Claims Auditing and Monitoring

In addition to reviewing high dollar claims, we also review the OIG work plan continuously and follow CMS recommendations on high-risk provider types. Investigators review the data mining report and take appropriate action. These actions include analyzing data and reviewing high-risk claims manually or referring them to SIU for more in-depth review and study of the specific

provider's patterns versus their peers. Depending on findings, we may develop new business rules to better detect future FWA; we are constantly improving processes by studying claims trends and patterns. These processes not only improve our detection of FWA but provide means to inform our prevention processes to proactively mitigate and eliminate FWA through provider education and improved prepay processes. Through these processes, we have developed an iterative testing and rapid-cycle improvement process to use what we learn and put it in practice in preventing and detecting FWA. Other analyses and methods include the following:

- **Internal applications** such as HCFS run enrollee analytics, including the following: eligibility to determine if the home address is a P.O. Box; checking for multiple enrollees living at the same address/using the same phone number; verifying enrollee address and phone number during provider visits; pulling any enrollees with high ER use; and sorting through obituary files or investigatory news articles that may include enrollees or providers, among others.
- **PA** enables Aetna to monitor the use of defined outpatient services and procedures as well as non-emergency or elective hospitalizations before the enrollee receives the service. PAs confirm requested services are for eligible enrollees and are included in the defined benefits; provided at an appropriate level of care and place of service; appropriate, timely, and cost-effective; coordinated with medical management; communicated to applicable operations areas (e.g., Finance, Enrollee Services, Provider Services) or per contractual requirement with external vendors; and documented accurately to facilitate timely reimbursement and reporting.

Aetna's West Virginia's PI staff communicates with the health plan clinical pharmacy manager, Mark Demary, on any matter of suspected pharmacy FWA. Mr. Demary can make referrals to the FWA team as needed regarding prescribers or pharmacies that may need some type of outreach/investigation and interacts with the state's pharmacy benefit manager.

We evaluate identified enrollees' utilization to determine that Aetna performs **targeted audits** (e.g., contract, benefit, provider, diagnosis, procedure, specific service, and place of service) on 2 percent of manually adjudicated claims and 15 percent of auto-adjudicated claims; and high dollar claims. Additionally, claims with billed amounts of $30,000 or greater are subject to 100 percent high-dollar audit review daily. Random statistically valid audits are conducted routinely

to identify and detect inappropriate claims and potential provider fraudulent billing. Audit findings are provided to the program integrity manager for review and action. At a minimum, the audits examine the following:

- The provider was contractually allowed to provide the service being billed
- The service provided is covered for the enrollee
- The appropriate level of care was used for the presenting condition
- The provider billed correctly for the services rendered
- The charges for services are reasonable
- There was evidence of excessive testing or referrals

Each audit includes key departmental concerns identified in addition to a summary of financial and procedural accuracy to begin remediation of risks based on audit findings. Aetna finalizes, publishes, and distributes monthly and quarterly audit results to track trends and system findings to the business units. The reports include trends by error type, claim identification, and analyst identification, enabling the Claim Operations department to conduct continuous quality improvement. Based on audit findings, management staff provide or track additional training and/or inclusion of additional claims edits or processing flags as needed. Aetna also performs **credit balance audits**, which include identifying, tracking, and pursuing recovery of overpaid funds to make certain Aetna has a comprehensive payment accuracy program. Our program integrity lead has trained providers since 2017 as part of our statewide provider forums. The key shared concepts help providers to do as follows:

- Strengthen internal compliance programs
- Self-audit (projected CMS requirement)
- Improve their claims integrity
- Identify FWA and inappropriate billing
- Recognize overpayments due to Aetna

Using Data Analytic Algorithms to Detect and Prevent Fraud

Aetna innovates in the use of data analytics and auto-identification of potentially fraudulent claims to facilitate detection and mitigation of enrollee, provider, subcontractor, and vendor FWA

throughout the claim's lifecycle from prepayment to recovery. Our data analytics system provides efficient and proactive discovery of new fraudulent schemes such as the overbilling of UDS in a national scheme related to the opioid crisis and related items specific to West Virginia. This included the following:

- Aetna placed all claims for breath alcohol testing on a prepayment review due to excessive billing by medication-assisted treatment providers
- Overperformance of not medically necessary urine pregnancy tests
- Coding overutilization of tobacco cessation codes

We allow for near real-time prepayment review capabilities to flag suspicious claims prior to adjudication. The data analytics of all Aetna plans are shared among the plans to leverage the information on commonly used providers and provider types. This creates efficiencies by reducing the need for pay-and-chase methods of recovery, fostering a comprehensive approach to addressing both enrollee and provider fraud by leveraging all available data sources to detect emerging fraudulent patterns. Our rules-based claims adjudication system maintains and processes health care administration data, providing increased efficiency. The provider module contains a 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 the claim, and the date of payment, including the check number. The system stores claim by specific benefit limits/lifetime benefit rules. It scrubs/edits this data for accuracy during claims processing and payment. Aetna's Medicaid Claim Quality Control department independently assesses the effectiveness of the Medicaid claims system configuration and claim procedures against the resulting adjudication process.

We conduct an annual review of the plan to identify high-dollar specialties, providers, and procedures codes. This can show which specialties to review for outlier behavior. In addition, **on a quarterly basis, we run a minimum of 25 tailored outlier reports of known fraudulent schemes** based on specialty and CPT codes to identify the top providers of certain services. The reports are referred to investigators for further review and appropriate action. At data mining meetings, FWA staff members, the medical director, clinicians, and certified coders discuss and prioritize data mining studies to analyze trends and schemes identified through various sources. **Table 6.11.1-1** provide the categorical overview of the billing outlier reports.

Table 6.11.1-1: Outlier Billing Reports to Identify Known Fraudulent Schemes

Scheme/Allegation	Unique Report(s)
Upcoding	8 reports
Modifier Misuse or Abuse Report	1 report
Misrepresentation of Services	5 reports
Excessive Charges/Billing	3 reports
Over-utilization report	1 report
Doctor Shopping	2 reports
Non-covered Service report	1 report
Not Medical Necessity	2 reports
Experimental and Investigational/Pass-through Billing	2 reports

HCFSs business rules are customizable at the health plan level to account for benefit variations and can be applied pre- and post-payment. This platform identifies providers with potential FWA behaviors and assigns them a risk score. We use the HCFS application screens to visualize all leads and billing activity as well as download the past 24 months' worth of claims for each lead. This helps us further avoid inappropriate billing, identifies, and mitigates provider confusion, and deters criminal activities, among others.

Subcontractor Oversight and Monitoring Processes

PI010	The Vendor should describe its oversight and monitoring process for any delegated functions and services, as provided by a subcontractor, in accordance with guidelines defined under the contract.

Aetna integrates subcontractor monitoring and oversight within our overall process monitoring and oversight as we do for all health plan functions. To assure we begin relationships with subcontractors effectively, we use a subcontractor pre-assessment questionnaire in the decision-making process. We require that each of the following subcontractors have in place internal controls, policies, and procedures to prevent and detect FWA and must have a formal Medicaid compliance plan with clear goals, assignments, measurements, and milestones:

- Cotiviti: Retrospective claims processing review
- eviCore: High-end radiology and pain management
- SKYGEN USA: Dental services
- VSP Vision Care: Vision care

When the subcontractor is a provider that also renders administrative services, Aetna's process includes a review of the prospective subcontractor's program for adherence to health plan and National Committee for Quality Assurance standards, and federal and state laws and regulations. We review relevant documentation before conducting an onsite assessment. The completed assessment report includes review of FWA processes and provides documentation of the prospective subcontractor's strengths and improvement opportunities and is used by the Quality Management/Utilization Management Committee to review and approve subcontracted relationships. Aetna staff conduct monthly meetings with SKYGEN USA, the West Virginia dental subcontractor, and provide FWA resources to our Pharmacy team that interacts with the West Virginia pharmacy benefit manager. The state recently requested assistance from us in analyzing a dental provider's billing practice of verifying services of another provider who was not enrolled with BMS.

Per contract requirements, Aetna policies require a written, signed agreement for all subcontracting arrangements. The agreement outlines the responsibilities of the parties; defines

their relationship, rights, and obligations; specifies how we monitor their performance including ; required state contract provisions and other terms.

All our subcontractors and their employees must participate in compliance and FWA training. We train our subcontractors in all areas of accountability and oversight for all functions and responsibilities delegated to them. In turn, we review their employee FWA program and verify that they provide employees FWA training. We monitor FWA activity through subcontractor meetings, including whether the subcontractor is delivering the required reports and training.

For our subcontractors, we provide information and training pursuant to Section 6032 of the Deficit Reduction Act of 2005. Under this regulation, any entity who receives or makes Title XIX (Medicaid) payments of at least $5,000,000 annually must establish written or electronic policies and procedures for the education of employees of affected entities regarding the False Claims Act and other laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

Monitoring Provider Fraud Related to Under-utilization and Member Fraud for Over-utilization of Services

PI011	The Vendor should describe its process for monitoring provider fraud for underutilization of services and member/provider fraud for overutilization of services.

Under-utilization and over-utilization of services are key aspects of FWA that concern Aetna. We review claims and member utilization profiles to make certain members receive the appropriate access to care to avoid both over and under-utilization of services. Member profiles play a pivotal role in the management of member care both by our integrated Care Management team, as well as by the member's medical home/PCP. Member profiles:

- Identify members who under- or-over utilized health services, including ER, hospital admissions, and prescribed medications, and could benefit from integrated care management

- Identify members who may lack appropriate access to needed services or could benefit from education about how to best use the health care system (e.g., persons with high ER usage)
- Identify medical homes/primary care providers that do not appear to be following recommended clinical practice guidelines or need to reach out to their assigned members more effectively and facilitate better management of the member's care
- Assist in supporting other internal health plan operations, such as concurrent review decisions, member appeals, and fraud and abuse detection

Under-utilization and FWA

Aetna encourages members to contact us when they suspect FWA is occurring related to their benefits. Because FWA detection and prevention methods often uncover patterns such as upcoding, we conduct annual provider training about program integrity and compliance electronically by way of online provider training modules and webinars. Our Provider Services department disseminates information about FWA training to providers via fax blasts and emails each year and collects the providers' signed attestations for themselves and their staff. This information is provided to the Department during the annual compliance program review process and in the board report. The Provider Services department also conducts annual provider forums and the SIU team participates to give providers information about trends, FWA training, and more to increase their knowledge and reduce abuse across the state.

Our investigator researches all relevant Aetna and Department policies and provider contracts, relationships, and the type and location of the members they serve. Considerations for investigation include, but are not limited to, high volume of services, dramatic change in frequency of use, and high-risk, problem-prone areas.

Examples of providers over-prescribing health care services include physical therapy treatments. Effective PA processes can mitigate errors or fraud in provider overprescribing for such services. Our Medical Management staff use PA, concurrent review, discharge planning,

retrospective review, and provider profiling processes, which serve as the first line of defense for preventing and detecting member FWA. Other examples of this work include the following:

- Verifying member eligibility
- Reviewing service medical necessity
- Determining the appropriateness of the service being authorized
- Verifying the service is covered
- Referring members to appropriate providers

Medical management reports allow the Program Integrity and Compliance teams to have multiple points of data to review to verify unusual patterns that may indicate potential fraud or abuse. Unusual or suspicious incidents are documented and reported. If the PA process indicates fraud or abuse, the PA will be denied, a notice of action is sent to the provider and the member, and a report is sent to the compliance officer. PA staff may have access to additional information and may be able to flag concerns when leading diagnostic services or requested procedures seemed to be misaligned or out of scope of best practices. The program integrity lead reviews trend and report findings for the Department through prescribed channels. In addition, we review state-provided pharmacy data within investigations to identify trends and patterns in provider prescribing and pharmacy shopping by members.

Mitigating Opioid Overprescribing by Dental Providers

From 2016 to the present, our dental subcontractor Avēsis identified 128 potential cases of dental provider FWA related to opioid super prescribers. These 128 cases were initially valued at $216,144. Through the appeals and claims correction processes, this amount was reduced to $141,944; thus far, Avēsis has recouped $45,370. Providers received education on appropriate prescribing and continue to be monitored.

Over-utilization and FWA

Aetna's person-centered approach encourages members to assume responsibility for their health, wellness, and care. We use the member handbook and newsletters, website, and Member Advisory Committee meetings as well as our verification of services process as ways to communicate with members and their caregivers (if applicable) about their responsibilities in

preventing and reporting instances of FWA. The member handbook and website provide information on various types of fraud and abuse, such as identification card fraud, inappropriate use of ER services, and prescription drug use and benefits. Each of these tools informs members on the definition of fraud and abuse, their responsibilities and those of others, and how and where to report suspected or known fraud and abuse. Members are encouraged to report all suspected FWA through Aetna's fraud hotline, the Department's fraud and abuse hotline, or by submitting an online fraud and abuse form via our web portal.

Member verification: Aetna is serious about tracking services and services billed to verify that the proper claims are tracked to the members receiving care and that no additional service claims are being billed for a member who did not receive the service. We also monitor for member utilization trends from a system standpoint—such as intervals between visits seem to be out of trend—when no new diagnosis appears.

We use real-time electronic health record data to identify members and confirm the accuracy of their contact information as part of our ongoing efforts to ensure that services are provided to the correct member. This process engages our integrated care management model to promote member safety and quality health care. For example, Aetna subscribes to a health information exchange's event notification service to receive timely notice when one of our members has an encounter with a hospital. The service securely transmits information about the member's visit, the facility, and the primary complaint helping us to improve care management, service coordination, and utilization management, as well as verifying service delivery. Aetna's additional member fraud prevention activities include PA, drug utilization review, and use of targeted audits, claim and data analytics, member accountability tools (i.e. explanations of

benefits and member portal), hotlines, mailers, and other strategies. The SIU team works proactively to identify fraud when a member is suspected of committing such acts. Additionally, this involves understanding that members may not be aware when their identification is stolen or being used in a fraudulent scheme.

Denying, Suspending, Nonrenewal, or Terminating Providers

PI012	The Vendor should describe its policies and procedures for denying, suspending, nonrenewal, or terminating affiliation with a contracting healthcare professional, including an appeals process, and for reporting serious quality deficiencies to appropriate authorities.

Aetna complies with 42 CFR 455.23 which requires the State Medicaid Agency to suspend all Medicaid payments to a provider after the Agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity, unless the agency has good cause not to suspend payments or suspend payment only in part. The rules governing payment suspensions based upon pending investigations of credible allegations of fraud apply to Medicaid managed care entities.

Aetna Policies and Procedures for Denying, Suspending, Nonrenewing, or Terminating Providers

Aetna ensures that all participating providers are enrolled with BMS as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR § Part 455, Subparts B and E as incorporated in 42 CFR § 438.608(b), prior to executing a provider agreement. Prior to paying claims to a non-participating provider that is not enrolled with West Virginia Medicaid, Aetna, at a minimum, verifies licensure and performs all federal database checks as specified at 42 CFR § 455.436 on all owners and managing employees. The Provider Relations department verifies ongoing provider eligibility by checking providers against the exclusion lists monthly. If a provider, owner, managing employee, board member, or

person with 5 percent or more controlling interest is found to be on one of these lists, Aetna's Provider Experience and Member Services departments work together to remove the provider and reassign the enrollee. Aetna maintains processes to disclose to the Department, within 30 calendar days of identification, any disciplinary actions that have been imposed on any licensed physician, physician assistant, nurse practitioner, or psychologist, or their governing body related to FWA as defined within the contract.

Aetna confirms that it is not controlled by a sanctioned individual. In the event that Aetna were to identify that a person, agent, managing employee, network provider, delegated entities or subcontractor appears on one or more of the exclusion lists (each an excluded person), appropriate action would be promptly implemented, which may include termination of the relationship with the excluded person and ceasing payments owed to the excluded person. Aetna maintains policies and procedures to support reporting of excluded parties, as required by the State, within two business days of identification.

As part of our recovery, reporting, and compliance processes, it may become necessary to provide education, suspend, or terminate a provider from contracting with Aetna. We follow our internal processes and procedures as well as state and federal regulations closely to make certain we address FWA appropriately and with the correct protocols to maintain the integrity of the provision of services to our enrollees. The following details our processes for making certain our provider education, suspension, and termination policies are followed consistently.

Provider education after investigation identifies waste: Once an investigation is complete after a thorough review of the allegation against relevant data and/or records, the case investigation findings are presented to the FWA Committee. The committee can decide to educate the provider

on the wasteful behavior, including but not limited to: upcoding, provider choosing an unidentified or general code when a more specific code would be appropriate, unbundling, etc.

Provider suspension or termination: As the investigator works the case, information might be identified, whether it be a medical records review, member verification of services, law enforcement activities, etc. that supports consideration of termination by the health plan. Our Aetna investigator(s) prepares a summary of the findings for the FWA Committee including, but not limited to the allegation, paid amounts, findings from the audit to date, etc. If the FWA Committee agrees to suspend and/or terminate the provider contract, Aetna's Provider Relations Department **carries out the direction and notifies the Department** through the monthly FWA report and provider termination, suspension report. The investigator requests a copy of the termination letter for the SIU file. At times Aetna network providers are terminated or suspended via requests from the Department and/or other state agencies. When we receive provider termination or suspension notice from the Department or other state agency, we follow the provider termination policy and notify the state through the monthly FWA report and provider termination/suspension report.

If a provider is disenrolled, de-credentialed, terminated, or removed from the active provider list, we provide the BMS the basis, reasons, or causes for such action and any and all documentation. Aetna cooperates with BMS when payment suspensions are imposed on the Medicaid provider. When we receive notice that payments to a provider have been suspended, we suspend payments within one business day if such provider is in our network and receives payments. When such notice is received, we respond to the notice within three business days and inform BMS of whether we have implemented the suspension. Aetna reports all of the

following information to BMS monthly: name of the suspended Aetna provider, date the suspension was imposed, date the suspension was discontinued, reason for discontinuing the suspension, amount of payments held, and if applicable, the good cause rationale for not suspending payment (for example, the provider is not enrolled in our network) or imposing a partial payment suspension. We understand that failure to suspend payments to the provider may result in BMS imposing contractual remedies. BMS is responsible for evaluating allegations of fraud and imposing payment suspensions, when appropriate, for those of our providers who are a part of the state fee-for-service network. Aetna continues to be responsible for initiating payment suspensions based on the credible allegation of fraud for its in-network providers who are not a part the state fee-for-service network. For payment suspensions initiated by Aetna, we must comply with all contractual requirements and 42 CFR 455.23.

Provider Appeals Process

Upon completion of either a prepayment or post-payment review in which an allegation is substantiated by evidence, the investigator is responsible for pursuing recovery of overpaid benefits resulting from the submission of improper claims containing FWA. Providers may appeal as detailed in our policy and procedures document related to Provider Appeals.

The provider has 30 days to submit additional documentation or rebut the determination or extrapolation. The provider may request and receive a copy of the findings of the medical review and if the provider disagrees with a claim determination by Aetna, they may go through our standard appeals process. The provider may also request a peer-to-peer discussion with the chief medical officer who conducted the review. Providers are given specific information regarding the findings and education where appropriate.

Overpayment Processes and Determinations

PI013	The Vendor should describe its policies regarding identification and recoupment of provider overpayments, and processes to coordinate with the Department.

Aetna understands that we will continue to be entitled to retain overpayment recoveries, including overpayments due to FWA that were first identified by us. We understand and comply with all BMS requirements related to overpayment processes and determinations. When directed by BMS we will recover established overpayments made to a provider by the State for performance or non-performance of activities not governed by this contract. When funds are recovered, we promptly notify BMS of any amount recovered. As directed, Aetna immediately provides the amount recovered to BMS, and understand that BMS may withhold the amount recovered from a payment otherwise owed to us. If the overpayment is not recoverable, Aetna promptly notifies BMS and provides an explanation stating why the overpayment is not collectible. Aetna understands that we are not entitled to any recovery under this section when BMS and any agent, including the State's fiscal agent or other agent, identifies and pursues overpayments, false claims, or fraudulent claims paid by us to a provider.

West Virginia's Innovative Breath Alcohol Testing Initiative

Effective January 2019, Aetna placed all claims for breath alcohol testing on a prepayment review. All claims required the symptomatology and narrative description of the suspected condition to justify testing for submission. If urine drug testing occurs on the same date of service, all urine drug test results need to be submitted with the breath alcohol testing claim. Results are as follows:

- **2018**: $402,513 paid on 15,937 claims
- **2019**: $84,330 paid on 3,209 claims
- **Policy cost savings:** $318,183

Aetna requires participating providers and non-participating providers to report overpayments and specify the reason for the overpayment in writing. The overpayment shall be returned to us within 60 calendar days after the date on which the payment was identified. Aetna complies with 42 CFR § 438.608(a)(2) by promptly reporting all overpayments identified or recovered.

Aetna understands the retention of overpayments is dependent upon the circumstances under which such overpayments are identified and investigated. We are proactive in identifying and taking action to recover provider overpayments timely as we have done in initiating our **Breath Alcohol Testing program.** The monthly FWA report submitted by Aetna pursuant to contract requirements and BMS' Notice of Program Integrity Activities will be a part of our deconfliction process. Deconfliction will occur regardless of the length of BMS' grace period.

Overpayment Determination and Collaboration with BMS

We understand and comply with BMS' right to recover provider overpayments, including those overpayments due to FWA, from Aetna if any of the following occurs: BMS or its contractor identifies an overpayment made by Aetna to the provider; the payment occurred outside the grace period, as defined by BMS; Aetna has not previously identified the overpayment via the deconfliction process, or the MFCU or other law enforcement entity is not pursuing the provider

BMS sends notice to Aetna with all information upon which the overpayment determination was based, along with a demand for payment. Aetna enters into a payment agreement within 30 calendar days of receiving notice and effectuate payment within 90 calendar days of notification. Failure to adhere to this process will result in liquidated damages as described in Appendix G. If Aetna is invoiced for the overpayment by BMS, and Aetna recovers the overpayment from the provider, the provider's sole remedy is under the provisions of the provider's contract with us. For provider appeals, as defined in *Aetna Policy: Practitioner Participation and Peer Review*, that arise from actions taken pursuant to this section, Aetna communicates the result of those appeals to BMS within 60 calendar days of the final decision. If the investigator finds suspected or confirmed FWA, we take appropriate action such as recoupment of payment, contract termination, or other disciplinary action. The case is also referred to the appropriate state and

federal regulatory agencies. We further understand and comply with BMS' right to recover provider overpayments, including those overpayments due to FWA, from the provider.

We understand we will continue to receive notices of its intent to collect from the provider and initiate recovery actions with the provider. If BMS chooses to collect the overpayment directly from a provider, we assign any rights it has to collect overpayments from the provider and that such payments recovered will be retained by BMS. Aetna advises our providers, via contract provision, addendum, notice or other suitable method, of the State's right to collect overpayments Aetna diligently engages in identifying and recovering overpayments that do not require a referral to the State and identifies overpayments on the monthly FWA report.

We understand that unless otherwise specified in this contract, when we or one of our subcontractors identify overpayments, we may recover and retain those overpayments directly from the providers, if the following occurs:

- Aetna was not required to abstain from collections from the provider
- BMS has not duplicated this recovery, consistent with this section
- Aetna followed proper procedures regarding fraud and/or abuse referrals to BMS
- Aetna properly and timely disclosed the required information on its monthly FWA report
- The encounter data is properly adjusted to reflect the recovery, and such recovery is not prohibited by federal or state law

Overpayment Recovery Process

Our investigator calculates the overpayment after confirming fee schedule amounts using the published fee schedules for the investigative period and determining whether to apply extrapolation to the overpayment. An extrapolated overpayment is calculated using the distribution of errors in the sample along with the proper error ratios. An overpayment letter to the provider is drafted, outlining the findings of the investigation and, overpayment amount.

As noted previously our appeals process allows the provider 30 days to submit additional documentation or rebut the determination or extrapolation. The provider may request and receive a copy of the medical review findings that we conducted and may request a peer-to-peer discussion with the CMO who conducted the review. Providers are given specific information regarding the findings and education where appropriate and can remit the overpayment in a single payment or enter a payment plan if necessary. The provider may be placed on a negative balance to recoup the funds from future payments if they fail to repay the health plan. Aetna engages in legal remedies if all other efforts fail. If an overpayment has been referred by us to BMS, due to suspected fraud or abuse, and the dollars are subsequently returned to Aetna, we may retain these overpayments directly from the provider. We follow all state required procedures for collection of overpayments including investigations and/or audits and their resulting recoveries begun by BMS or by an entity contracted with BMS.

Aetna Participation in Fraud Recoveries

Aetna submits fraud and abuse referrals to BMS using the prescribed form. Referral information submitted to BMS by Aetna is distributed to all potentially impacted MCOs, along with an RFI. Upon receipt of the referral information and RFI, we respond by the due date included in the RFI. We understand that failure to respond timely, completely, and accurately may result in Aetna not participating in any related fraud recoveries and may also result in liquidated damages as described in **Appendix G** of our contract with the Department.

Impact on Medicaid Medical Loss Ratio and Rate Setting

Aetna complies with 42 CFR 438 regarding deducting overpayment recoveries from incurred claims when calculating the medical loss ratio, and encounter data must be adjusted appropriately for rate setting purposes.

12. Information Management Systems

The Vendor should refer to the business specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Information Management Systems (IM) as part of their bid. The Vendor's narrative response should not exceed 50 pages.

As an incumbent managed care plan, we will continue to leverage our local experience and expertise to provide the West Virginia Bureau for Medical Services' (Department) Medicaid Managed Care program with an integrated suite of innovative technologies and tools that drive our advanced care coordination and service delivery transformation efforts. Our management information system (MIS) not only meets the Department's requirements, it is positioned to address the upcoming changes confronting Medicaid programs. Our MIS supports the State's strategic initiatives by meeting the following goals:

- Tailoring services and improving individual linkages to the right services at the right time
- Supporting social determinants of health automation initiatives, including online information and referral resources that streamline the administrative processes, reduce the need for members to repeat their stories, and complete multiple redundant forms
- Facilitating accurate data transfer with providers to improve Healthcare Effectiveness Data and Information Set (HEDIS) reporting

Our proprietary system delivers advanced capabilities and performance using the highest industry standards, controls, business continuity, security, and redundancy features to assure the maximum level of data protection. Our local health plan team, in collaboration with our national Information Technology (IT) team, ensures our technology platform continues to deliver performance, innovation, and value to Mountain Health Trust, West Virginia Health Bridge, and West Virginia Children's Health Insurance Program (WVCHIP) stakeholders.

Given our 23-year history collaborating with the Department and supporting Mountain Health Trust and Mountain Health Bridge members and providers, we are confident our management information system provides the strongest solution for the State and successfully meets the

Department's contractual and operational requirements. Aetna continuously evaluates and examines opportunities to improve the quality, access to, and efficiency of our system capabilities by collaborating with the West Virginia Program Integrity Office as seen in the Blue Box Initiative, rebate improvement process, and implementation of our Special Investigations Unit data sharing. Our digital strategy to improving clinical engagement and simplifying administrative processes, along with our introduction of personalized health solutions, will materially improve the member and provider experience with us. Our digital strategy, in this context, refers to three key areas: operations, products and services, and finally our constituent experience. Through digitalization, we have transformed manual, back-office processes leveraging new, automated solutions and enhanced products and services with emerging technology and personalized services and experiences custom-tailored for each member.

Aetna's Data Security Approach

IM001	The Vendor should describe its written policies and procedures for safeguarding and maintaining the confidentiality of data, including differences for adult and children populations.
IM002	The Vendor should provide its plan for how it will maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance, and maintain this compliance, throughout the life of the contract at no additional cost to the Department.
IM003	The Vendor should describe its policies to ensure that its staff, contracted providers, and all subcontractors that provide cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation maintain the confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI).

[IM001] At Aetna, protecting member data—keeping all information safe and secure—is of utmost importance. We continue to push our global cybersecurity program beyond what is standard for our industry and we continually work to improve security while making digital navigation more convenient for each individual. We also invest in documented best practices, processes, and controls to stay a step ahead of ever-evolving data security issues. We commit

to continue providing access to best practice health care for West Virginia Medicaid program members while diligently protecting each enrollee's privacy. We comply with both the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act, and we comply with all Department requirements, as demonstrated by formal results from external audits.

Safeguarding and Maintaining the Confidentiality of Data

We maintain the confidentiality of all enrollee data across our membership, regardless of enrollee age. Our enterprise-wide and West Virginia-specific policies and procedures for safeguarding and maintaining the confidentiality of data cover members of any age. Our reporting team monitors the appropriate use and distribution of age-sensitive data, such as our child population. More broadly, our privacy policies and procedures include the following data and physical security controls we use to safeguard and maintain the confidentiality of all enrollee data:

- Layered encryption, including encryption of data in motion that is internal to our WAN and across the Internet, and encryption of production data at rest as well as backup media encryption
- Secure hardware disposal and destruction of all physical media types removed from all user equipment and datacenters
- Data loss prevention controls, including Symantec's data loss prevention solutions for perimeter web, email, and network traffic, as well as internal data at rest scanning
- Secure access management practices, including preregistration, identity, authorization, business need validation for access, and legally binding agreements (employee, contractor)
- Physical security monitoring, including the use of a centralized, monitored access management system for monitoring and tracking access, anomalous access activity monitoring and reporting of privileged access, and integrated video surveillance systems
- Physical access controls (e.g., card access readers, anti-pass-back entrance/exit, tailgate detection)

[IM002] Complying with Health Insurance Portability and Accountability Act Standards

The key to HIPAA compliancy is the system security of our members' privacy information. Our core system is fully compliant with HIPAA, Health Information Technology for Economic and Clinical Health in 42 USC 17931, Section 6504(a) of the Affordable Care Act, and other

applicable federal and state laws and regulations. Our compliance efforts are supported by the Aetna Medicaid organization's IT Team and our Aetna Enterprise Compliance teams, who implement and maintain our HIPAA system security plan.

HIPAA Technology Compliance Team

The Aetna Medicaid organization's IT department maintains a separate and independent Compliance and Governance team, which continuously reviews our information management system practices and HIPAA compliance policy updates. This team acts to create an information management system-focused layer to assist all information management system employees with ongoing HIPAA education and implementation. This team works with Aetna Better Health of West Virginia staff, including local legal and compliance officers, to address any rules and regulations that arise from federal and state laws and directly impact our plan.

Our Medicaid IT Compliance and Governance team takes on the role of first responders when questions arise within our information management system team regarding HIPAA policy interpretation, audits, and data management compliance. For example, this team interprets and documents new Aetna-wide rules to ensure all Medicaid IT leaders and staff understand and comply with updated requirements around system and database access.

This team's activities supplement the already comprehensive activities and responsibilities assigned to our at-large enterprise compliance teams, who implement and maintain the plan for full HIPAA compliancy via the information security program.

Prevention of Security Incidents

Our information security program involves creating, administering, and overseeing policies to help ensure the prevention, detection, containment, and correction of security breaches. We maintain a comprehensive solution for handling incidents 24/7/365. Our Global Security team

discusses incidents that come in from a variety of methods during daily threat calls. There are response time requirements based on the levels of potential risk for each incident. Splunk is the security information and event management solution in place to provide monitoring of incidents.

Aetna has documented procedures in place for response to or reporting of security incidents.

Breach of Unsecured Protected Health Information (PHI)

In 2019, Aetna became aware of a privacy breach that stemmed from an incident suffered by a third-party vendor. This vendor's security team discovered that an employee electronic mailbox had been leveraged to distributed large quantities of spam email; some of the spam email was found on Aetna-employee email accounts.

We immediately notified the State of the incident and described the action steps we initiated in response to the incident.

Action Steps:

- Our vendor's Information Security team immediately took steps to lock down this employee's account and make sure no others could access it. Both the vendor and Aetna immediately undertook an investigation to find out if any other email accounts were hacked.
- None of our other systems or networks were accessed. Our Information Security team put extra protections on all our email accounts, and we notified all employees of the incident. We updated our required yearly employee training and other educational programs to help employees keep their computers more secure. We notified law enforcement about this hacking event as well. We also set up a dedicated toll-free helpline with identification (ID) experts to assist employees.

Risk Management

Aetna has a mission to safeguard confidential information and protect employees in the workplace. We continuously explore innovative solutions in an effort to keep up with new security challenges. Cybersecurity threats continue to increase, and the diversity of threat actors and tactics in health care has evolved significantly in recent years. With new technologies introduced constantly, technology and process adaptability and resiliency are critical. As such, information security has become a cornerstone of Aetna's operating model, influencing how Aetna chooses to do business.

As part of our plan, we take a risk-based approach to information security management. The company determines the appropriate level of protection by assessing the relative importance and classification of data and, based on the assessment, manages risk by reviewing threats and vulnerabilities on a daily and quarterly basis. Risk management activities help keep Aetna abreast of industry and environmental events and promote adaptability to a rapidly changing environment. The security risk management process in place is shared with employees, plan sponsors, auditors, and regulators, which helps promote transparency.

Adhering to HIPAA Security Regulations

We have maintained strict compliance with HIPAA security regulations since the day they became effective. We fully document and adopt security standards as soon as they become effective to ensure that the integrity and confidentiality of electronic records and transmissions are continuously preserved. We systematically reassess and update our policies and procedures to address member-specific data and any relevant modifications to federal and state law.

Through these actions, we have established the following procedures, in our compliancy plan, to maintain adherence to HIPAA security regulations:

- Formalized a security incident policy and procedure
- Created security and awareness training and other activities for all staff, including posters in our facilities and town hall meetings, and distribution of compliance fun facts to keep awareness high
- Implemented mass mailing printing controls to avoid any unintended PHI disclosure; staff requesting a mass mailing complete a request form and submit the document to be mailed to our privacy officer. The officer reviews the form and document, makes recommendations where PHI can be omitted, and formally approves the mailing.
- Implemented common facility access controls and security management procedures
- Added the appropriate security language to subcontractor and provider agreements

[IM003] Maintaining Confidentiality of PII and PHI

Our privacy practices regarding individually identifiable health information follow federal and state laws and regulations and apply to all contracted providers and subcontractors. We have

established a corporate Privacy Office, which has overall responsibility for developing policies and procedures to safeguard personally identifiable information (PII)/PHI against uses and disclosures that are inconsistent with applicable law.

To ensure immediate attention and responsiveness to PII- and PHI-related issues Our onsite compliance officer, who is supported by the Aetna organization's Privacy Office, manages a compliance program that includes comprehensive training, ongoing education, and continuous policy and procedure review designed to maintain our members' privacy and confidentiality. Our compliance officer, who has extensive health care law experience and 15 years of health care and Medicaid industry experience, is responsible for conducting mandatory privacy policies and procedures training and education for our staff, contracted providers, and subcontractors, and for overseeing the implementation and enforcement of these PII and PHI policies and procedures.

Before sharing any member-related information, we obtain written permission from members and their families/guardians (when applicable) that specifies the type of information we can share and with whom. We store completed release forms in our database for easy access by care managers. Call center staff verify telephone callers' identity by asking for a member's date of birth, identification number, and/or address, and review our database to ensure there is a documented release of information before providing member PHI. We do not share third-party information and redirect practitioners to contact other providers directly to obtain the records. When we receive an authorized request for information, we electronically send it in PDF format via secure email or establish a secure data exchange.

For example, if we receive a request for member health information, the following conditions must be met before we would release member health information:

- Members must be able to provide member identity information before their own health information, or that of minor dependents, will be provided to them.
- Other requestors may need to provide Aetna with additional documentation or evidence of their entitlement to the member health information in question.
- If a requestor calls with someone else on the line, we can disclose member-specific health information (Level I Information and/or Level II Information) to both individuals if (i) the requestor qualifies for such disclosure and (ii) the requestor explicitly authorizes us to share the information with the other person.
- For any subsequent disclosures when that particular requestor is not on the line, the requestor must either complete and submit Aetna's "Authorization for Release of Protected Health Information" ("Third Party Authorization"), provide us with a health care power-of-attorney, or call and give us another explicit authorization with the other person on the line.

Protected Health Information

We have developed policies and procedures that address the proper handling, use, and disclosure of members' PHI while administering their health care benefits and providing high-quality customer service, and we maintain them. We update policies and procedures annually and as needed to stay current with changes in legislation and to verify that they are current and complete. Any time we update our policies and procedures, we also update training materials or other related communications and notify our staff. We have adopted the following policies and procedures to safeguard the use of PHI:

- Implementing, enforcing, and providing training and education for our staff on policies and procedures regarding the appropriate uses and disclosures of PHI, including monthly distribution of compliance fact sheets
- Establishing the proper handling, use, and disclosure of members' PHI while administering their health care benefits and providing an appropriate level of customer service
- Recognizing each member's right to privacy and treating all their health information with the strictest confidentiality and obtaining their permission to release it

Sharing health information with others only when it is appropriate for aiding delivery of health care services, administering health care benefits or health care payments, or as otherwise required by law as previously described.

Protecting Data in Motion and At-Rest

To protect data in motion and at rest, Aetna has implemented NextGen server architecture for all Medicaid production environments. Our databases reside in an environment with full disk encryption, ensuring encryption of data at-rest. Additionally, data in motion is encrypted internally to encompass our wide network area as well as across the Internet. Our database servers are protected by physical and logical access controls within a highly secured data center. We encrypt all backup media, and we destroy retired hardware following strict disposal protocols further protecting data. Our internal database activity is monitored by Guardium software to capture all activity including reading and accessing our databases. Additionally, we have a 100 percent compliance training rate concerning data protection and protecting member health information for our staff, contracted providers, and subcontractors.

Security Awareness and Education

A key component of Aetna's security program is employee education and awareness of the critical role each of us plays in protecting member health information, provider and subcontractor data, the Department's data, and our interfaces and platforms. Our front-line personnel stay well informed about current threats via internal communication channels, and they receive training on how to validate inquiries for personal data. To ensure all staff and contingent workers are aware and understand the importance of their role in protecting Aetna's information and resources, all workers are required to complete, upon commencement of employment and then annually, an online Information Security Awareness course.

Security Audits

As part of our ongoing commitment toward protecting the confidentiality, integrity, and availability of our members' PHI, Aetna contracts with IBM Security Services to perform an annual HIPAA Security Health Check audit of existing controls as one of the key assessments

performed along with other continuous audit activities throughout the year. The most recent completed assessment, conducted between April 10 and May 10, 2019, was facilitated through a series of onsite interviews, as well as a review of all documented policies, processes, procedures and guidelines, and a comparison of Aetna's security practices against HIPAA security standards as it relates to the Omnibus Final Rule.

Internally, we audit a series of technical controls designed to either eliminate security defects altogether or to facilitate the identification of potential vulnerabilities as early within the lifecycle as possible. These controls can be classified into the following categories:

- Application obfuscation technologies, which help provide Aetna's applications with protection against reverse engineering and other forms of compromise
- Implementation of static code review technologies on the developer's workstation in a manner that not only supports the identification and remediation of defects, but also provides developers with feedback that helps avoid creating such defects in the future

Commendation from IBM
For Maintaining Strong Security Controls for PHI

We received the following commendation regarding the finalized assessment:

"Aetna has done a tremendous job within the enterprise of addressing and minimizing security concerns by taking a risk-based approach and putting an emphasis on strong security controls where electronic PHI (ePHI) is processed transmitted and stored. The daily risk and threat monitoring of Aetna assets is leading-edge and ensures a high awareness of threat vectors into the environment. In addition, a very robust security awareness campaign is also in place with multiple methods of distribution to ensure that staff fully understand and take part of securing sensitive information. There are continuous audits and assessments occurring throughout the year and Aetna has shown due diligence in being proactive in its approach to security and providing all the necessary documentation/evidence to the various assessors in a timely and organized manner."

IBM Security Services concluded:

"Aetna takes information security seriously within the organization and strives to focus on various technical controls for the protection of ePHI. Aetna has numerous audits performed throughout the year, and as such, remains in good standing with the various compliance requirement. …Aetna is performing well in all areas, thus meeting all the HIPAA Security Rule requirements."

The following list represents a sample of our internal audit controls:

- Detective application security controls facilitate the identification and remediation of defects identified after development activity has ceased.
- Policies pertaining to the implementation of open source code components, defined by a cross-functional team and enforced through a series of technical controls integrated at several layers.
- Threat modeling practices, which enable us to outline threats to an application and design appropriate countermeasures.
- Next-generation authentication platform based on a comprehensive analytical model that leverages a variety of behavioral and biometric attributes which, when analyzed in correlation with one another, allows for instantaneous authentication decisions to be made at assurance levels that far exceed traditional binary forms of authentication.

Using Information to Implement and Maintain our Quality Program

IM004	The Vendor should describe how its health information system collects, integrates, analyzes, and reports data necessary to implement and maintain its Quality Assessment and Performance Improvement (QAPI) Program.

Our health information systems use data collection methods that allow for reporting of data analytics specific to health outcomes and metrics. These methods include trending of measures and performance to show both positive and negative trends. We monitor these trends via heat maps, regional performance, and population demographics. Our population assessment provides details on data that enable us to develop predictive analytics on enrollee behavior, as well as stratification of enrollee conditions. We use our technology infrastructure and databases as tools described in **Table 6.12.1-1** to help us identify, track, analyze, and report data to support implementation and maintenance of our Quality Assessment and Performance Improvement (QAPI) program.

Table 6.12.1-1: Internal Tools and Technology Infrastructure

Technology Tool	Description
Claims management system	Collection of medical claims for inpatient, outpatient, and professional services
HEDIS National Committee for Quality Assurance-	For generation of annual HEDIS and non-standard HEDIS rates, creation of monthly trend reports, and provider gap in care lists

Technology Tool	Description
certified data platform	
Hotspot analytics	Identification of enrollee presence by gender, race, ethnicity, culture, HEDIS, and non-standard performance indicators by regional and statewide levels
Electronic population health management platform	Identifies enrollee health risk factors and social determinant of health indicators, and alerts care manager of gaps in services, emergency department disparity dashboard, and health equity dashboard at the regional and statewide levels
Medical record audits	Provider adherence to medical record, HEDIS standards, and clinical practice guidelines
Grievances and appeals data platform	Collection and tracking of enrollee and provider satisfaction with the plan and services rendered
Quality data platform	Tracking of provider preventable conditions, health care-acquired conditions, and potential quality of care concerns

Our utilization/quality improvement technology subsystem maintains and integrates data from many sources, both internal and external, to provide a comprehensive repository which staff use for monitoring and developing action items that can be enrollee- and provider-specific.

Our West Virginia QAPI is designed to continuously improve and monitor the medical care, enrollee safety, and delivery of services to enrollees that include a focus on the enrollee's biological, psychological, and social well-being. Our local Medicaid Quality Management team performs the following coordination efforts with our plan leadership and multiple departments, such as Care Management, Utilization Management, Member Services, and Provider Services, to ensure HEDIS reporting needs are met:

- Creating outbound eligibility file information to support receipt of vendor data
- Receiving and storing all inbound supplemental data utilized in HEDIS
- Compiling/maintaining all needed data to support HEDIS reporting within the HEDIS data mart
- Preparing all data files utilized to operate the HEDIS software
- Receiving data files from the data warehouse and runs monthly/annual HEDIS rates

- Supporting HEDIS intervention evaluation and reporting efforts
- Supporting pay for performance

These supporting data sources include claims/encounters including behavioral health from our claims processing system. Our standard supplemental data includes lab results, vision, dental, pharmacy, immunization registries, and Department historical claim data. Our non-standard supplemental data includes year-round medical record review results. Please refer to **Figure 6.12.1-1**, which details the flow of quality data through our various technology applications. Our goal is to collect, aggregate, and integrate applicable data into a common system to support accurate analysis and reporting. These results can be used by our Population Health Management team, for example, to improve their understanding of members' care needs and to develop programs to address these needs.

Figure 6.12.1-2 depicts the broader reach of our data sources. Our goal is to build high quality analytical models, using multiple data sources, to improve how we organize and support the delivery of care. We achieve this goal by centralizing all Aetna Medicaid organization operation and analytical data content, based on a common data governance structure, to develop a stable, scalable, and centralized environment to analyze, interpret, report, and improve member outcomes.

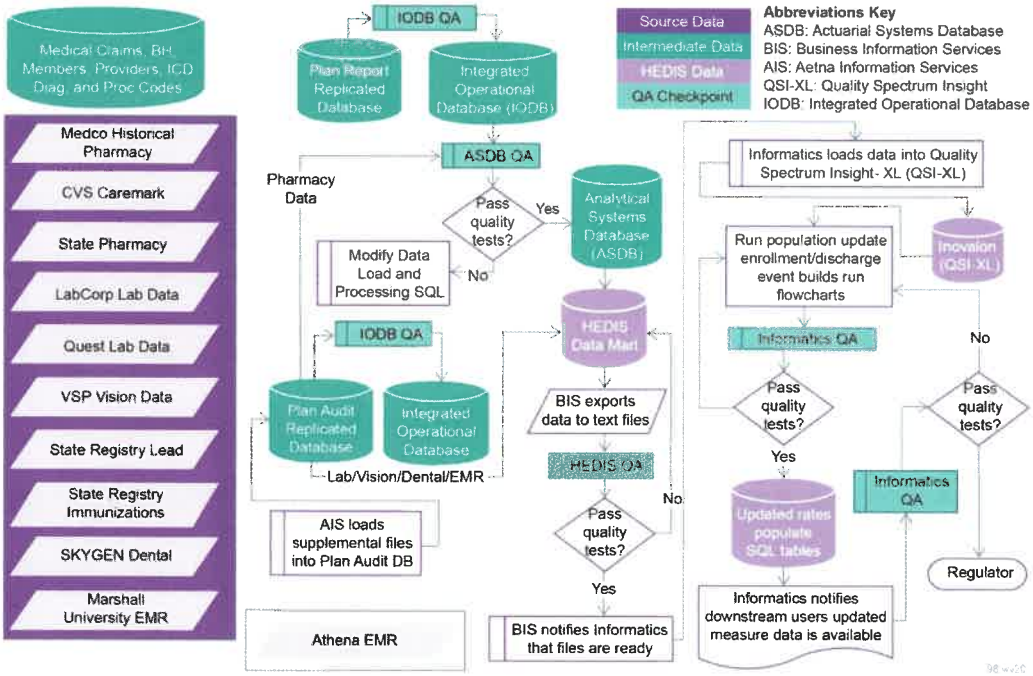


Figure 6.12.1-1: HEDIS and Quality Data Integration Process Flow

The quality data integration process depicts the highly structured relationship between our claims management system, QNXT™, our vendor information, our different data flows, and our quality assurance checkpoints.

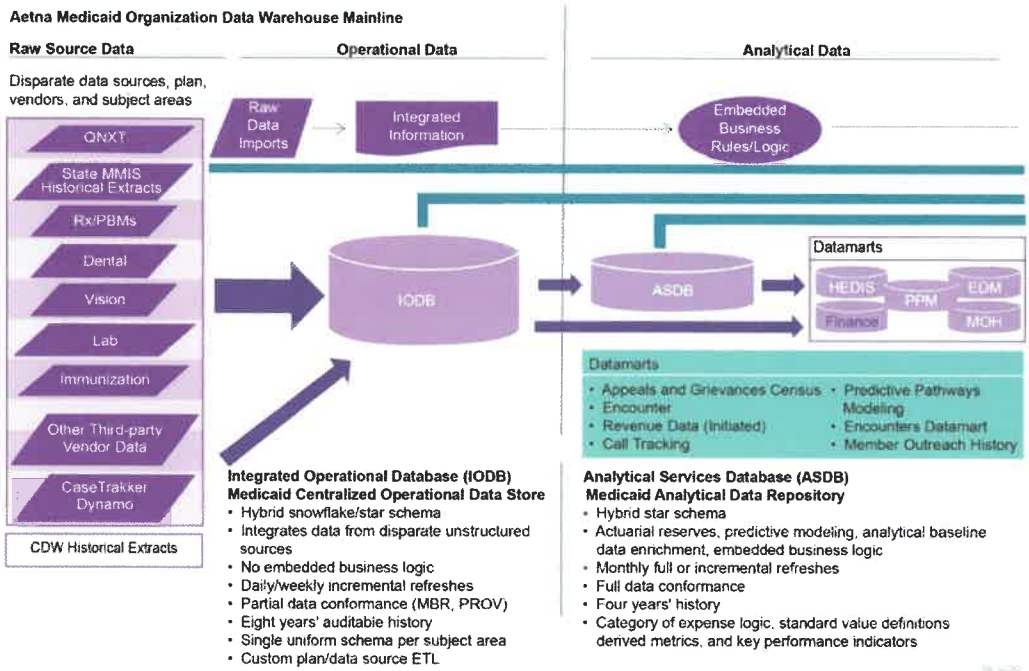


Figure 6.12.1-2: Aetna Medicaid Organization Data Warehouse Mainline Flow Chart

We integrate our raw data sources into a centralized repository to support our analytics and the impact of our Medicaid program.

Quality Assessment and Performance Improvement Program and Related Data analysis

Our Informatics team creates a primary comprehensive data source in our Medicaid data warehouse comprised of data from our operational systems. We also maintain external vendor data through data files, data system transfers, and extensible markup language files. Our multilayered data collection, analytics, and reporting/interface structure is robust and designed to handle and protect large amounts of data. Aetna maintains (and requires each subcontractor to maintain) records, books, documents, and information adequate to verify that services are provided and payments made in accordance with this contract and other relevant federal requirements. We retain such records for a period of 10 years after the applicable contract expiration date or until the resolution of any associated litigation, claim, financial management review, or audit, whichever is longer.

We use structured query language reporting tables or data building blocks that serve as a foundation for all our reporting needs. Our Informatics teams combines key data elements across the organization from the following sources:

- Operational, analytical, and transactional databases
- Other data marts, like HEDIS, finance, encounters, and appeal and grievances
- New sources being developed for clinical events and social determinants

Our Informatics team then consolidates the data set to facilitate consistent analysis. Analysts across the enterprise are then able to develop reports from one server, one database, and only a few tables, rather than using disparate sources. This approach simplifies the way we access data and ensures consistent analysis of our data.

The Aetna Medicaid organization encourages collaboration between our affiliate health plans and national Shared Services departments. One example of our shared engagement is our reporting collaboration group. This reporting collaboration group serves as a forum for groups to

share information and experiences with a broad group of individuals. The function of the reporting collaboration group is a cross-functional group of Aetna plan level reporting managers and subject area experts, led by Medicaid Informatics, to execute collaborative reporting governance by doing the following:

- Maintaining an intranet site and Microsoft Teams site for communication and collaboration
- Maintaining reporting catalog for managing content, discontinuing obsolete reports, and identifying best practices across the Aetna Medicaid organization
- Provide central repository that plans can access to find report examples
- Identifying opportunities to create and utilize standard logic and reports across plans
- Cultivating a center of excellence around reporting for better education and training for standard and Department reports
- Serving as an escalation forum to identify gaps, reconcile conflicting needs, address questions, and set priorities
- Acting as primary contact and expert for designated reports and help identify contacts and business area owners for reports
- Optimizing resources across the Medicaid segment to meet reporting needs

Quality Assessment and Performance Improvement Program and Related Reporting

Our approach to reporting provides timely, consolidated, relevant, and accessible information. This is essential to informed decision-making and critical ongoing program monitoring. Aetna has a long and successful history in West Virginia, and we have used this history and experience to develop a comprehensive QAPI reporting package. While we comply with the State's requirement to compile and submit accurate reports, our QAPI reporting efforts also support detailed analysis and support decision-making efforts by the Department and within Aetna. Through a combination of comprehensive data sources, we generate data analysis reports, and in turn, encourage deep thought analysis and data-driven decision-making. Aetna complies with all current federal and state laws and regulations that govern reporting, disclosure, and certification requirements. This includes the development, maintenance, and oversight of member data that is member-age sensitive (e.g., adults and children). We catalog every statutory, regulatory, and compliance-based report across the organization. These reports

are centralized and standardized with associated metrics to improve data integrity and consistency. The report catalog can identify existing reports that meet (or meet with minor modification) the requirements of any new requests, minimizing the need to develop any reports from scratch. Centralizing reporting in this manner improves data integrity while providing complete, accurate, and timely submission of reports. Moreover, we have used the results and feedback from the states to develop more enhanced, informational, and actionable models and reporting. The lessons learned have also led us to develop additional coordinated population health capabilities to help providers support the care and management of enrollees.

We provide timely, accurate, and compliant reports to help the Department make informed decisions and promote our mutual goals of providing high-quality, cost-effective, and integrated care to enrollees. Our Informatics team works with the plan to generate all required operational reports, adhere to required report formats (including using prescribed templates), and meet the required reporting schedule. Our Informatics team builds the reports and the plan assumes responsibility for reviewing, cross-checking, and certifying the data, information, and documents (e.g., web content accessibility guidelines-compliant for outward-facing reports). Required reports are submitted to the Department on or before the date required in an agreed-upon format and in accordance with its submission procedures; we acknowledge the Department may alter the reporting formats, content, and reporting frequencies at any time.

Our Medicaid Compliance team uses Archer, a tracking system that ensures that all required reports and contractual deliverables are tracked and submitted to regulators accurately and timely. Archer operates in the following two phases:

- Our Informatics team builds reports for each contract deliverable.

- Our Compliance team tracks and documents contract deliverables, as well as reports on the timeliness and accuracy of our reporting; plan compliance officers retain copies of signed attestations and final reports in Archer for archival and auditing.

Aetna uses the following tools to bring information from multiple components to provide the Department with an accessible combined view of project and performance information:

- SQL Server Management Studio
- SQL Server Reporting Services
- Crystal Reports
- Tableau
- SAS
- Cognos
- Microsoft SharePoint
- Microsoft Excel
- Power BI

These standardized tools and repeatable processes give us a clearly defined roadmap for consistent and predictable high-quality reporting and work products. In addition to these conventional reporting tools, we also leverage the advanced data visualization capability of Tableau to provide a more interactive, user-driven, self-serve experience in accessing and analyzing data. The following figure in this narrative shows how our Medicaid data warehouse interacts with all of our systems as well as our external entities' systems. Please refer to **Figure 6.12.1-3**. Aetna's Warehousing Capabilities, which depict our data warehousing capabilities.

Supporting Data Analysis

Through our capability, collection, and storage of such vast amounts of data, our Informatics team supports data analysis needs for departments and teams companywide. This ultimately supports our decision-making and ability to recommend improvements/enhancements to programs in support of the Department's goal of creating a healthier West Virginia. We have created 28 dashboards and 20 demonstrations and training videos for more than 400 active users and have received approximately 21,500 server hits to enhance staff knowledge of our data goals. A following list summarizes the dashboards we offer access to by department:

- Trend and utilization management dashboard includes utilization management, readmissions, observations vs. one/two-day stays, emergency department, neonatal intensive care unit, outpatient urine drug testing, medical claims trends, authorization trends, and inpatient performance-to-target.
- Population health dashboard details eligibility trends, demographics, enrollee conditions, consolidated outreach and risk evaluation predictive analytics for risk stratification, risk adjustment, and month-over-month risk adjustment.
- Operations dashboard includes utilization management, claims key indicators, case management executive, care management, HEDIS trends in case management, and call tracking.
- Pharmacy dashboard (when applicable) summarizes prescription claims, pharmacy summary, weekly prescription lite, pharmacy high-utilizer, and pharmacy market share.
- Quality and value-based services dashboard includes gaps in care and value-based services quality.

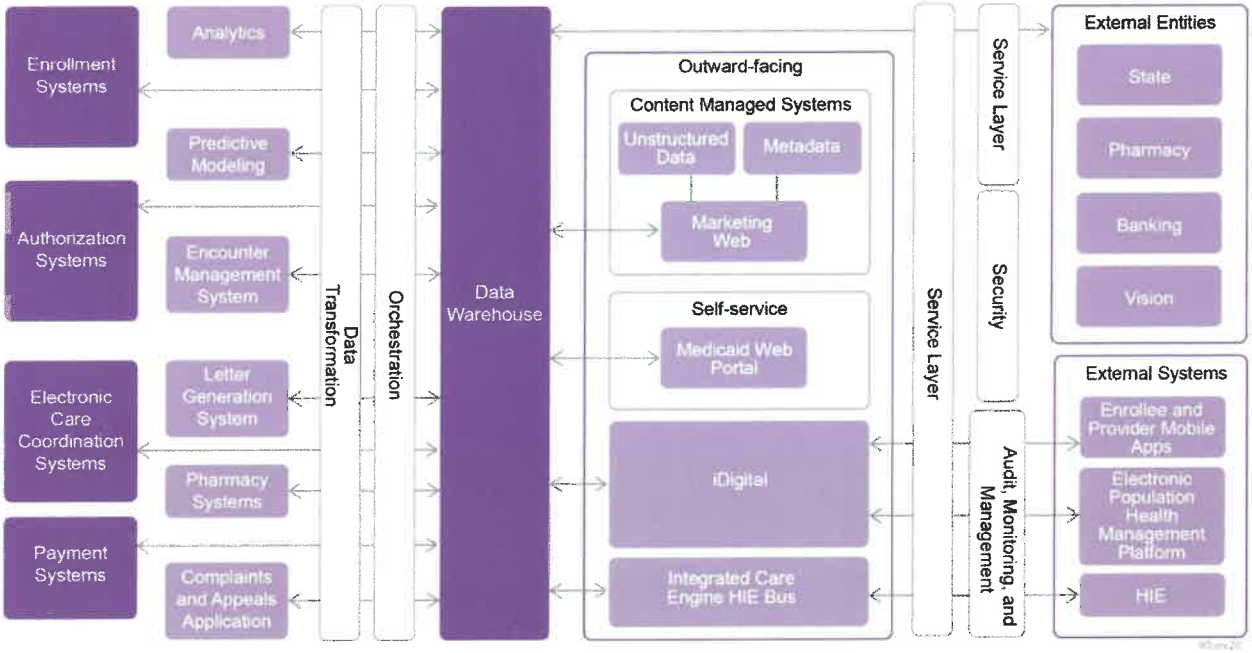


Figure 6.12.1-3: Aetna's Warehousing Capabilities

This graphic displays our warehousing capabilities and the structured data interaction between our enrollment, authorization, electronic care coordination, and payment systems, as well as our data warehouse and our security and monitoring technology platforms.

Health information system and processes utilized

IM005	The Vendor should describe the flexibility of its health information system and processes utilized to develop requirements, configure, and test system changes as per new or modified contract requirements.

Our systems have been integrated with the Department since 2011 and are currently fully operational. Any additions included in the new contract will follow our change management process which provides a structured, flexible, and fully recoverable framework in which to

implement and manage system change releases on schedule and per federal, state, and contract-specific requirements. This change management process includes the following steps in the application development process:

- Analysis
- Development
- Peer review and testing
- Approval prior to implementation into production
- Post-implementation validation to ensure all impacted production systems are functioned as designed by the change requirements

Risk Mitigation Strategies for System Changes

We have significant experience navigating and managing risk throughout the deployment of new technologies. One detailed example of our risk management capability is our adoption of our DevSecOps methodology for system implementations. This methodology transforms change management into a fully automated continuous integration and delivery process tailored to focus on speed and quality. The emphasis is on the collaboration and communication of software developers, code/configuration management, and testing teams, while automating the process of software delivery and infrastructure changes. This methodology supports the establishment of a culture and environment where building, testing, and releasing software can happen rapidly, frequently, and of higher quality. The resulting transformation includes the following components:

- **Continuous integration:** Merging code into a common source code repository and executing automated build, quality check and unit testing.
- **Using of state-of-the-art code management technology:** Aetna's one source code repository allow development teams to share source code for all applications amongst all the teams. This repository tool enables developers to store, exchange, trade, and evaluate code collectively, exponentially increasing the power any one team.
- **Continuous delivery:** Rapidly deploying the development version of the software into higher environments, including production. In addition to peer reviews and functional code libraries, Aetna source delivery tools support 100 percent automated application deployments through all pre-production and production environments, eliminating application failures due to incomplete code solutions.

- **Continuous testing:** Testing of code at every stage of project lifecycle in an automated manner and providing feedback on quality. Repetitive automated testing leaves the business stakeholder with the only manual handling for end-user validation. Using industry-leading security software, CheckMarx, delivery teams employ gated security scans for every deployment in the pre-production environments. This provides static and interactive application security testing at every phase of delivery. The integrated process scans uncompiled code and searches for hundreds of known security vulnerabilities, reducing and remediating risk before changes ever make it to production. Additional testing is described below.
- **Continuous monitoring:** Process and tools to intelligently monitor, analyze, and manage solutions and IT infrastructure in the production environment of the application.

Within our modernized, agile-based, DevSecOps software delivery model (please refer to **Figure 6.12.1-4**), we continuously monitor the utilization of our servers in real time, using tools such as Tivoli, AppDynamics, and Splunk. If our server utilization is deemed excessive, we add servers to the cluster to increase central processing units, random access memory, and disk capacity. This advanced technology delivery cycle enables our systems to quickly build, test, and release new capability to match any escalation in demand from Mountain Health Trust, West Virginia Health Bridge, and WVCHIP while maintaining system operational uptime and performance.

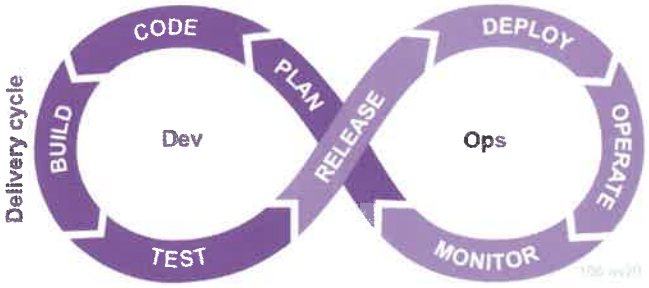


Figure 6.12.1-4: DevSecOps Delivery Cycle
We employ a DevSecOps software delivery process, which combines software development with infrastructure monitoring and operations to shorten our development lifecycle, provide enhanced platform stability, and deliver timely solutions to the State.

As an example, our West Virginia Medicaid plan enrolled approximately 15,000 new members in the second quarter of 2019 after an existing managed care organization exited the market. Moreover, we experienced a 17 percent increase in our West Virginia Mountain Health Trust membership during the last two quarters of 2015, with the majority of this increase occurring

between the months of June and September (we experienced 11 percent growth during this period). During each of these time periods, we met 100 percent of our monthly claim timeliness metrics.

Testing Methodology Which Supports DevSecOps Delivery Methodology

The Aetna Medicaid organization's testing methodology and MIS provides an objective, independent view of our software implementation to allow the business to validate that our systems are functioning as mandated by contract requirements, including Department systems such as the Medicaid Management Information System, and integrated eligibility solution. Testing is a critical component of all implementation projects and is performed throughout all the phases of the project lifecycle by our subject matter experts and end users. We have adopted DevSecOps principles, which include fully automated continuous integration and continuous delivery for our implementations, including a detailed test plan that ensures all requirements are successfully built, tested, and deployed per the deployment schedule. Our testing protocol utilizes waterfall and agile methodologies to plan, assign, execute, and report on the status of all testing across functional areas. Functional areas and vendors involved include claims, eligibility, member services, medical management, encounters, and compliance. The following types of testing are used during the project lifecycle (note that each type of testing is accompanied by robust testing artifacts, including, but not limited to, strategies, scripts/test cases, and test results summary that can be traced back to Department requirements):

- **Unit testing:** Tests functionality and is executed by developer who builds the code or code module. Developers are all trained on in-sprint automation techniques which allows our scrum teams to create automated acceptance tests at the time of application development, which verifies that piece of code has a built-in test(s) for accuracy.
- **System testing (positive and negative):** Performed to assess the proper behavior of an application based on business requirements and application, which includes the desired action based on specific input. In the absence of action when incorrect information is supplied, changes to application functionality are validated against preceding and post-workflow steps.

- **Department testing:** We exchange data file(s) with the Department to validate that system changes and logic are compatible with requirements and is certified by the Department if needed. In addition, we have a dedicated team to facilitate testing between the State, vendors, and Aetna utilizing any state-specific testing tools required.

The following types of testing in different phases of the software development lifecycle workflows allow for all components of implementation to be tested thoroughly and exhaustively, including subcontractor changes. Each type of testing is accompanied by robust deliverables, including, but not limited to, test strategy, test scripts, and test results summary:

- **Specialty/performance testing:** Performed to assess the proper behavior of an application based on documented requirements, this testing occurs to validate how the application behaves under various conditions (i.e., browser testing performed on web applications to assess compatibility on different browsers such as Internet Explorer and Google Chrome, performance testing on proper screen response time, or file processing time).
- **Automated regression testing:** Examines the application to see whether it is operating in a business-as-usual mode and that it has not been affected negatively by changes; automated test scripts are executed where possible to validate that there are no additional impacts on upstream and downstream applications.
- **End-to-end testing:** Performed to see if data flows from one application to the other and works as expected (e.g., claims end-to-end testing includes data capture, file load/import, adjudication, payment check run, encounter process, and reporting).
- **User acceptance and functional demonstrations:** Validates the business requirements using defined user acceptance test strategies, plans, and script/test cases and verifies that the application/file(s) functions as expected and no defects are encountered. Additionally, process demonstrations are completed at the end of each sprint to ensure end user decisionmakers verify in real time the accuracy of the delivered functions.
- **Production checkout testing:** Confirms that all application changes have been migrated successfully to the production environment and all functionality is working properly.

Our testing team leverages industry standards tools and best practices in accordance with our testing methodology. We can deliver changes within days which are fully built and tested, all with minimal manual intervention. The process provides visibility to status, defects, feature progress, and other software delivery metrics, while automatically moving software code through the delivery platform. Our software testing provides an objective, independent view of the software to allow the business to understand the risks of its implementation. Aetna's testing platform is designed to discover impacts to new code or new configurations in minutes of

delivery to the testing environment. Please refer to **Figure 6.12.1-5** for an expression of the different phases of all our testing components.

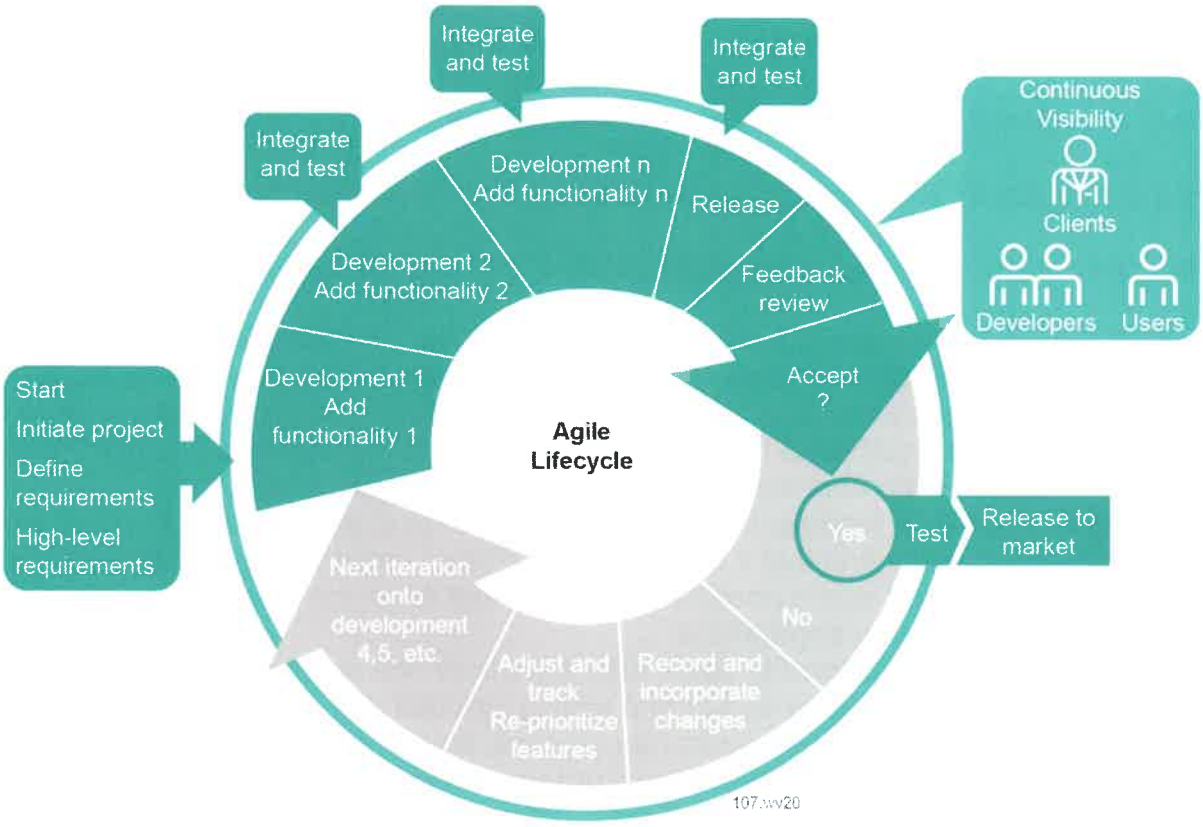


Figure 6.12.1-5: Aetna's Agile Lifecycle Flow
Our software delivery methodology enables continual workflow and feedback on product attributes, features, and corresponding test data, ensuring all implementation requirements are tested exhaustively at each step.

Scalability Assessment Process

Our scalability assessment process (please refer to **Figure 6.12.1-6**) continuously explores, tests, and evaluates methods for expanding on the flexibility of our system to meet Mountain Health Trust, West Virginia Health Bridge, and WVCHIP member and provider needs. This continuous assessment process gives our MIS team the capability to scale our systems to meet the State's changing needs.

Annually we perform an extensive scalability assessment to ensure our systems are well positioned to support projected growth across membership, transaction volume, and user capacity. This assessment evaluates all applications, including all interfaces and dependencies across our subsystems. We review each application and identify any constraints that may inhibit application performance in the event of a significant (e.g., 100 percent+) growth in demand. This scalability assessment is comprehensive and emphasizes the following capabilities:

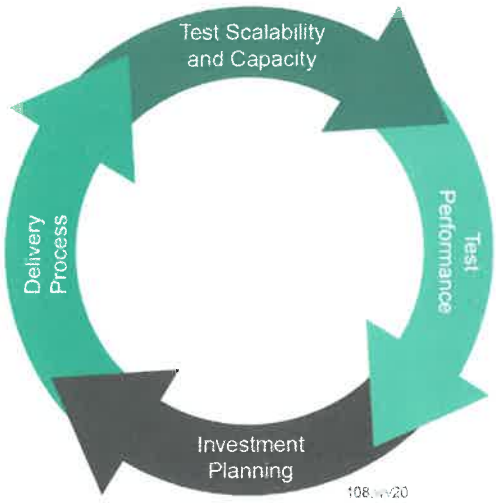


Figure 6.12.1-6: Scalability Assessment Process
This figure summarizes the integrated annual scalability process from assessment through planning and delivery, which enables us to scale our systems to meet the State's changing needs.

- **MIS scalability:** Ability of the application and its infrastructure to accommodate an increase in volume (e.g., users, transactions, members) by adding proportional infrastructure capacity (e.g., central processing units, memory, storage)
- **Capacity:** Growth that can be supported by existing hardware allocations (e.g., central processing units, memory, direct access storage devices), assuming no application constraints are encountered as a result of that growth
- **Performance:** Ability of the application and its infrastructure to provide a consistent response which meets or exceeds defined Service Level Agreements

Upon conclusion of the assessment, we initiate an investment planning and delivery process to resolve any constraints. This annual process ensures our applications are continuously assessed, positioned to ensure maximum performance under exceedingly high-volume situations, and able to scale to support planned or unplanned growth within Mountain Health Trust, West Virginia Health Bridge, and WVCHIP.

System Diagram

Our Mountain Health Trust, West Virginia Health Bridge, and WVCHIP MIS architectural diagram (please refer to **Figure 6.12.1-7**) depicts the major subsystems and corresponding components we use to interface with or support our overall management information system.

Management Information System Functionality

Our system interfaces are integrated to provide optimal functionality for the Mountain Health Trust program and for WVCHIP. These systems are designed and well-positioned to be flexible and to scale to benefit the health care provider needs for all Mountain Health Trust and WVCHIP enrollees. **Table 6.12.1-2** lists our MIS system components, includes a brief description of each component and how the component is used to support Mountain Health Trust and WVCHIP programs. All systems are supported and managed using the innovative software delivery and support processes as described above.

Business Continuity and Disaster Recovery

IM006	The Vendor should provide its business continuity and disaster recovery plan for the technology and infrastructure components of business operations with its bid.

We pride ourselves on being a reliable partner to the Department for the past 23 years, including during times of natural disasters, emergencies, cybersecurity, and other threats. In keeping with Aetna's commitment to provide the highest quality service to its customers, our local leadership works with our national Shared Services team to review best practices and enhance the comprehensive Business Continuity Management program we developed to manage business disruptions. For this response, we are submitting the technology and infrastructure components of our Business Continuity Plan. We will be submitting our Disaster Recovery Plan, Business Continuity Plan, Information Security Plan, and Systems Quality Assurance Plan when requested.

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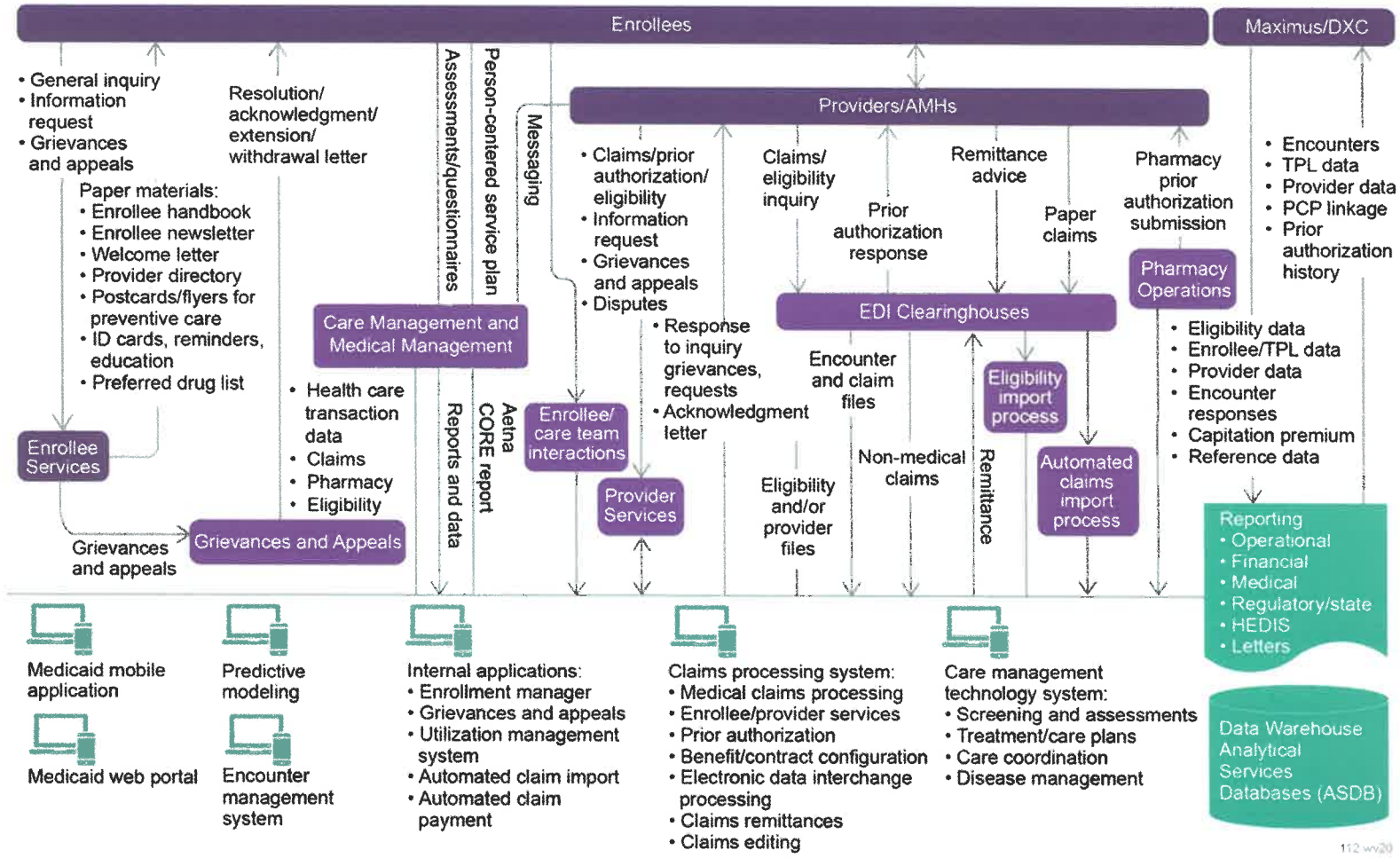


Figure 6.12.1-7: Aetna's Management Information System Architecture

This diagram illustrates the relationship between Aetna's MIS systems, applications, and related components, all in support of the Mountain Health Trust, West Virginia Health Bridge, and WVCHIP.

Table 6.12.1-2: Aetna Information System Capabilities

System Component (alphabetical order)	Description	Purpose
Aetna Better Health Member Portal	Secure portal is available to all members and optimized for use with smartphones and tablets; provides on-demand services; and is compatible with Section 508 of the Americans with Disabilities Act.	• Claim search • Authorization search • View identification card and member benefits • View prescriptions • Secure messaging to request a new primary care provider (PCP), contact Member Services, and get information about a health condition • Access case management records
Aetna Better Health Member Website	Publicly available website is available in English or Spanish with one click; provides on-demand provider search; includes access to the member handbook, includes Mountain Health Trust, covered services, and benefits information; includes instructions on how to file complaints and appeals; includes links to community resources, service management, and health plan contact information; is optimized for use with smartphones and tablets; and is compatible with Section 508 of the Americans with Disabilities Act.	• Assist members to Identify available Mountain Health Trust network providers, facilities, urgent care centers, and walk-in clinics; verify information in the member and provider manuals; and identify the appropriate behavioral health managed care organization for an individual member • Provide access to the formulary drug list to determine if a drug is covered by the plan • Provide member education • Provide members with information on our quality program • Allow members to submit inquiries • Educate members and providers on the tools available to them (e.g., West Virginia form)
Aetna Better Health Mobile App	Mobile app is free for iOS and Android smartphones; simplifies how members find and locate a provider; includes access to our member	• Search for providers, facilities, urgent care centers, and walk-in clinics • Electronic member ID card (online or offline)

System Component (alphabetical order)	Description	Purpose
	handbook, details about member's profile, current medications, medication claim history, claim search, and ID card; supports secure communication requests to Member Services and care managers and includes designated caregivers who help members with their health care needs.	• View claims, coverage, and personal health records • Complete health assessments – target completion date of Q4 2020 • Enroll in online health coaching • Communicate securely with health plan resources
Aetna Grievance and Appeals System	System logs and tracks complaints, grievances, and Fair Hearing requests for complete, accurate, and prompt resolution.	• Track, trend, and document complaints, grievances, and appeals received by the health plan • Enable accurate and complete documentation and adherence to turnaround timeliness
Aetna Inpatient Census Tool	Tool monitors and is used to manage members receiving inpatient care; documents the member's readmission risk scores, assigned care managers, and discharge planning details.	Provide a daily census of inpatient cases for metrics reporting, staff assignment, and referencing concurrent review and case management
Aetna Provider Portal	Portal provides public and protected-access sections; includes access to the provider manual, lists program updates, supports prior authorization (PA) requests and PA status, supports member eligibility and claim status inquiries, lists provider panel members, and includes search function for other health plan participating providers.	• Provide information to the provider community • Post provider profiles/utilization reports • Post provider gaps in care reports • Educate providers on practice guidelines, HEDIS billing and documentation, quality improvement activities and outcomes, and Early and Periodic Screening, Diagnostic and Treatment requirements • Submit authorization requests by the provider • Validate eligibility information; check claim status; check payment and remit status • Access members' care management records

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System Component (alphabetical order)	Description	Purpose
Aetna Quality Management Issues Application	Enterprise application tracks and trends quality of care investigation results at the health plan and service level.	Document investigation and outcomes related to potential quality of care issues
Analytical Application Web	Interactive, point-and-click query tool accesses reports, drills down into data, and exports information from the Aetna Medicaid Organization Data Warehouse; provides a centralized security and administration framework to applications, tools, or reports requiring high-security, reliability, and availability; sits on a web farm and supports any information type, including .NET-based applications, Tableau reports, structured query language server reporting services, and Crystal reports.	Create following reports: • Provider profile • Provider utilization data • Plan standard
Apttus	Online provider contract management system	• Automated contract management • Create unified and simplified experience for providers
Availity Provider Portal	Single provider portal that providers can use for multiple payers, meaning one provider login and one tool for providers to learn.	• Rollout of parallel functions in 2020 (target complete Q4 2020) • Request and respond to eligibility and benefits Inquiries • View member identification cards • View panel roster (PCP assignments) • View remittance • View claim attachments (health plan solicited) • Add/inquire about precertification and referrals • Amend or add attachments to precertification

System Component (alphabetical order)	Description	Purpose
		• Submit specialty pharmacy prior authorizations • eviCore • Contact Aetna • Electric funds transfer email notification • Pharmacy authorizations • Support portal access • Compliance reporting; Medicare attestation • Access to education and training
Axway Secure Transport	Enterprise-grade platform services as the file transfer book of record; manages secure file transfers between the Department and Aetna, between Aetna and providers, as well as between Aetna and outside vendors and the Department.	• Manage file transfers both externally and internally • Provide both push and pull capabilities • Perform high-volume automated file transfers between systems, sites, lines of business, and external partners, and implement user-driven communications between folder and portal-based file sharing.
Business Intelligence Information Gateway	Standard reporting and dashboard suite sourced from the Medicaid data warehouse. Provides information users can quickly and reliably access, including key performance indicators and actionable or operational information in trend management, utilization management, risk adjustment, service management, pharmacy reporting, value-based solutions, HEDIS, and operational reporting; includes a web-based reporting tool built using the Tableau software application.	Provide reports such as the following: • Utilization (over- and under-utilization) • Category of expense • Paid claim utilization

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System Component (alphabetical order)	Description	Purpose
Electronic Population Health Management Platform	Captures information in one place to create a 360-degree, unified view of members' data for providers at the point of care; enables the member-centered care team to manage care in real time regardless of care setting; facilitates community-based collaboration among traditional and non-traditional providers on behalf of members in a manner that aligns with Department goals.	• Communicate dashboard-level data to providers related to their member panels • Provide reports related to gaps in care and HEDIS measures
ClaimCheck and Cotiviti	Code auditing solution that supports our claim adjudication module; applies guidelines from industry-standard coding sources to analyze claims for accuracy and consistency with Aetna policies and procedures and national correct coding standards.	Provide correct coding claim editing
Clinical Authorization System	Processes pharmacy PAs; enables providers to check PA status (system capable, but not currently utilized under current contract)	Process pharmacy PA requests
Consolidated Outreach and Risk Evaluation (CORE™)	Predictive modeling that identifies high-risk members; used to identify the highest risk members based on health status, disease burden, hospitalizations, and emergency department utilization and costs, enabling Aetna to focus on high-risk members for our integrated case management program.	Stratify members for case management
Dynamo Care Management System	Fully integrated, web-based information system for physical and behavioral health case management; includes a complete suite of functional, physical,	• Document case management (primary system) • Determine member's risk level

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CRFP 0511 BMS2000000002

System Component (alphabetical order)	Description	Purpose
	and behavioral health assessments and service planning tools; offers monitoring functions, including access to members and providers through our secure portal.	• Determine gaps in care and document HEDIS outreach • Assist in quality of care investigations • Collect information from submitted obstetrical needs assessment forms
Edifecs	Stores encounter data from vendors; formats data to meet BMS' requirements; screens data for accuracy, timeliness, and completeness before submission to BMS; processes the most current coding protocols.	Extract and validate claim information for encounter submission to BMS in alignment with all BMS' encounter requirements
Enrollment Manager	Automated rules-based application that loads and processes enrollment data.	• Load membership data received via an 834-member file into QNXT member module • Process coordination of benefits and third-party liability records respective to member enrollment • Generate enrollment load reports
GMC iNotify	Correspondent management system that generates and stores member and provider Notice of Action letter; facilitates and tracks key dates in the authorization process.	Communicate with providers and members regarding the status of authorizations
Informatics Clinical Event System	Enterprise data aggregation and warehousing system that holds population health-specific data on a single platform; accessible to external systems; and aggregates data from internal provider sources and our claim and service management systems.	• Create population health reports, including gaps in care • Provide physician profile reports • Help providers manage member care

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System Component (alphabetical order)	Description	Purpose
Management Oversight Tracking Tool	Tracks oversight activities that meet and exceed the Department's and Aetna's requirements for delegates and vendors; identifies contacts and audit dates.	Document delegated credentialing information and oversight activities
Medicaid Data Warehouse (MDW)	Stores and provides a single source for all critical, historical Aetna Medicaid organization operational and analytical data content from disparate internal and external vendor data sources; supports access to MDW data through integrated operational database, analytical services database, and HEDIS (registered trademark of NCQA); supports predictive pathways modeling; finance data marts address informatics, actuarial services, finance, medical economics, medical management, pharmacy, and various health plan data needs; supports rapid, repeatable onboarding of operational health plan data into a common structure; loads data at a defined refresh frequency from replicated QNXT database instances; supports optimized or preconfigured queries for day-to-day reporting.	• Create technology enablement strategy for clinical, provider, and data management solutions such as population health management • Store the centralized operational and analytical data content repository • Provide data necessary for standard and ad hoc reports, among other West Virginia-based performance measures, and claim and provider utilization reports
Provider Experience Toolset (ProPAT, ProReport, ProFax)	Automated tools route incoming faxes and process and report prior authorization data.	• ProPAT: Assist providers in understanding whether treatment or procedures require prior authorization • ProReport: Access to information respective to provider's panel (used by providers) • ProFax: Receive, store, and respond to provider faxes

System Component (alphabetical order)	Description	Purpose
Provider Network Tracking Database	Cloud-based application-tracking tool that facilitates interdepartmental communication, enabling users to work collaboratively. Aetna uses this application to do the following: • Track all provider submissions and meet the Department's provider credentialing/re-credentialing status requirements • Monitor the provider ID and perform an automatic validation of the provider's status against our provider datafile • Track Aetna education and site visit activities to ensure accurate and adequate reporting back to the Department.	• Track provider recruitment • Track provider site visits • Track provider credentialing applications
QNXT™	Application is used to configure Mountain Health Trust benefit package information. This application handles claims, eligibility, member enrollment, service authorization, provider enrollment, and data management functions, edits that align with the Department's encounter data reporting requirements, member and provider service tracking, contract configuration, and reference file management including claim processing and payment data; the application can process, take cost avoidance measures on, and pay claims following all regulatory and contractual requirements.	• Capture authorization data used in claim payment and claim or authorization inquiry • Research the member's authorization history by non-clinical staff • Review member demographics, eligibility, and PCP information, both current and historical • Research calls, research claims, research enrollment history, and identify member's location to assist in planning service referrals • Document member and provider interactions with the health plan • Capture and maintain provider demographics, network status, and contract information • Review the provider's relevant information

REQUEST FOR PROPOSAL

Department for Health and Human Resources
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System Component (alphabetical order)	Description	Purpose
		• Document provider interactions with the health plan • Process claims • Review claim determinations • Document interactions related to claim payment inquiries
Quality CORE	Analytical application that provides high-level quality measures tracked against yearly goals or incentives; measures and tracks member adherence; and generates intervention lists for member outreach.	Obtain the following data: • HEDIS data • Member adherence rates • Provider gaps and adherence rates
Quality Spectrum Insight	Produces reports for HEDIS and other performance measures; programmed based on HEDIS, accreditation, and Department performance measures.	Produce HEDIS and West Virginia performance measure data monthly and for the annual project
Quest Analytics	Plots provider and practitioner availability based on the Department's requirements; supports monitoring of primary care and maternity wellness indicators and selected high-volume specialists.	Determine accessibility of providers based on geographic data
RxClaim/PeopleSoft	Supports Caremark PCS pharmacy benefit management services; RxClaim supports pharmacy claim processing and member pharmacy eligibility (system capable, but not currently utilized under current contract) PeopleSoft is a view-only system indicating member pharmacy eligibility, covered benefits, and claim information; supports members and	• Process pharmacy claims • View prescription history, copay information, and claim/fill data, including rejections (used by Aetna member services representatives) • View member prescription history, claim status, and medications

System Component (alphabetical order)	Description	Purpose
	providers in resolving member fill/refill issues via clinical authorization system.	
Single User View	Unifies various systems to help member services representatives service the member calls.	• Manage member calls • Unify multiple systems used by member services representatives • Improve member experience • Reduce complexity when working with multiple applications
Splunk (Monitoring Tool)	Enterprise platform used to track and monitor system data and to provide early alerts. These alerts enable Aetna to provide immediate response to issues as well as gain deep insights as to the root causes. These insights reduce downtime to minutes from hours or days. This solution helps the Aetna Medicaid organization to provide better services and functionality for the most used features and to identify areas of concern for its users without requiring direct feedback.	Advanced analytics enabling Aetna to learn from its users across multiple platforms and applications

Our Incident Management Plan (the staff-focused aspect of our Business Continuity Plan) ensures a strategic approach to business recovery and staff safety for all impacted business areas. Our staff is dedicated to supporting quick recovery of critical operations through timely resource and infrastructure allocations within the predefined recovery times.

We remain committed to maintaining a business continuity plan that fully protects the availability, integrity, and security of its members, providers, staff, and subcontractors/vendors during unexpected disruption of services, incidents, or natural disasters. Aetna has made careful choices to anticipate and address the State's needs to continue to provide high-quality health care services to members even during business interruptions. We do this by ensuring we can continue essential business functions during or immediately following failures or disasters to safeguard our members' health and our providers' ability to treat and support members in a safe place, and to address any vendor/subcontractor issues that would impede that goal.

From the technology and infrastructure perspective, Aetna is committed to preventing the loss of information and maintaining the continual availability of provided services to our members, providers, subcontractors, and other stakeholders. We achieve this commitment through our deployment of a comprehensive, effective, and proven disaster recovery plan for the electronic records and files we maintain.

Disaster Recovery Plan for Restoring and Maintaining Operations

Aetna's disaster backup and recovery strategy, referenced here as our disaster recovery (DR) plan, is a nationally managed function we use to support our West Virginia-based operations during natural or human-induced disasters or any other occurrence that damages our systems or data. Our national Shared Services team works with the West Virginia leadership to

incorporate and address local requirements in the DR plan. Our Shared Services team also works with the West Virginia leadership to coordinate and provide regular training to our local health plan staff on the DR strategy and on how to implement this plan.

Our DR plan entails the following:

- Addresses our critical business workgroup operations and the processes for mitigating the effects of brief or extended outages to our critical services and systems, including the following:
  - Analytical services database
  - Care management subsystem
  - Claims and eligibility management subsystem
  - Provider and member subsystems, including our secure web portal
  - Information security applications
  - Local administrative applications
  - Physical security systems
  - Third-party data loss
- Provides escalation and notification procedures to ensure recovery team members, affected partners, and business unit owners are engaged immediately after an event
- Provides outreach protocols for notifying and engaging Mountain Health Trust, West Virginia Health Bridge, and WVCHIP members and providers as soon as is safely possible after a disaster

Our DR efforts leverage the internal computer processing capacity of our state-of-the-art and hardened computer data centers, which are located in multiple states. Our data centers are equipped with fire suppression systems, dual incoming power feeds, uninterruptible power supply units, and backup diesel generators, which provide 24/7/365 operations. These data centers house our computer processing platforms and are load-balanced and supplemented by quick-ship services in case of a disaster. Aetna maintains contracts with national vendors to obtain replacement equipment and supplemental capacity, as needed, to ensure our recovery time objectives will be met.

Aetna's software-related DR plan documents technical and management contacts, application recovery protocols, application dependencies, integrated system synchronization, and checkout

procedures. Our local plan leadership and our Shared Services team validate our DR plans semiannually with the business users and application owners, and we jointly perform periodic exercises to test these DR plans.

Backup and Disaster Recovery Systems, Architecture and Frameworks, Capabilities, Governance, and Procedures

Resiliency forms the core of Aetna's data security approach, especially during a natural disaster or other event(s) that disrupts our business. Our data centers and key applications will withstand any natural disaster or state of emergency to prevent any type of data loss that could obstruct the standard operating procedures at our local plan level. Furthermore, our data security controls are consistently applied to all locations. Therefore, we are confident our data will remain secure if we need to temporarily relocate our operations to other in-network locations.

Backup and Disaster Recovery Systems

Aetna's Shared Services team securely backs up our infrastructure and application-based data daily. We perform full system backups weekly, with nightly incremental backups. For our databases, full backups are completed each weekend with differentials taken nightly along with transactional backups stored every 15 minutes to our network-attached storage units. These database backups ensure no data is lost due to system and/or infrastructure failures.

We replicate data storage to alternate data centers in real time. We also replicate virtual tape to alternate data centers and use strict protocols to transport physical tapes to a secure off-site storage facility. We complete near real-time data replication to an alternate data center, which includes validated technology controls to protect against corruption. This process is designed to ensure our data will not be lost in the event of system failure.

Should a system failure result in requiring data restoration, any gaps in data that result between the point in time of the data restore and the time of systems failure will be reprocessed and recovered by Aetna, which is our standard supported recovery process. This reprocessing effort is more efficient and reliable due to the batch-based nature of our data processing system.

We back up our adjudication system's database and non-database files using NetBackup. In the event of a system failure, these backup files will be restored as part of our standard recovery process. In addition, we perform annual disaster recovery testing to validate our recovery processes.

We leverage tools like Integrits, a vendor utility service, to analyze our databases daily for corruption. We perform this analysis in addition to our standard batch data processing integrity checks. The Aetna national Shared Services team also works with local plan leadership to continuously explore innovative solutions to identify and address new security challenges. For example, in 2017, Aetna's Shared Services team partnered with the Aetna Better Health of West Virginia's IT director to implement Aetna's information security initiatives surrounding a social security protection project. The IT director ensured, through research and collaboration with State agencies and vendors, that removal of social security values from certain Department and internal files would not interrupt daily work processes, including member enrollment processes. We removed member social security numbers from our internal systems, vendor files, and Department files. Due to this collaboration, we established a policy and specific protocols that define who has access to member social security information and how that information is secured and accessed. In addition to this type of local collaboration, our Shared Services team performs the following activities:

- Performs a top-down, risk-based approach to optimize our security defenses and security solutions. This effort includes a quarterly top-10 risk analysis that focuses on the greatest

risks based upon internal information and numerous sources of risk and threat intelligence. Each risk is broken down into detailed threat use-cases and compared to our defense posture. Each of the top 10 risks have all the corresponding security controls, solutions, and processes mapped to each risk. Each of these security measures are reassessed to determine the revisions, replacements, enhancements, or additional security solutions that will be required to mitigate the new risks and threat data.

- Holds a series of recurring meetings, attended by a broad range of internal security and technology functional area representatives, where we collect the latest information directly from the source companies and developers about innovative security solutions. We use these Security Technology Exploratory Evaluation Process introduction meetings to identify the most innovative and Aetna-aligned security solution providers, and we invite these providers to present the technical solutions to our security operations teams.
- Offers a comprehensive internal global security education program to ensure our security control process and solution owners attend conferences, webinars, and presentations to remain current with the latest solutions and innovations relevant to their area of security control responsibilities.
- Supports an internal function dedicated to technology and security architectures that identifies innovative solutions and standards for the entire enterprise to consider as we investigate and solution products and services.
- Leverages the expertise of review and evaluation services (e.g., Gartner) and consulting/contracting services (e.g., Ernst & Young) to provide additional context and perspectives to our internal solutioning process to ensure our leadership team has access to and understands the latest and most innovative ideas are available to us.

Disaster Recovery Architecture and Framework

We configured our DR architecture to address our physical and system requirements during a disaster. Our physical configuration supports recovery for each of our geographical locations, including West Virginia, the corresponding facility requirements, and data security. During a disaster, our systems architecture is designed to initially protect data, to then support secure access to the data, and finally, to recover our applications and initiate services within our designated recovery time objectives. Our corresponding DR framework is fully configured and tested to ensure we can recover our physical assets safely and efficiently, and to transfer our systems to a designated location and recover services as quickly as possible. We use the following infrastructure resources to support our enterprise-wide DR framework:

- Aetna uses three top-tier internet service providers (ISPs) for Internet access. All Aetna Internet services are routed diversely through different cities and central offices to minimize the probability of a single failure impacting all ISPs concurrently.
- Our Connecticut data center supports local access for these ISP services, which run on high-speed, diversely routed fiber rings. Access between our nationally distributed data centers is supported via these fiber rings.
- Aetna's ISP circuits each connect to a primary router, with a connected secondary router that automatically becomes the primary router if the other router fails.
- All devices—routers, firewalls, and servers on the external and demilitarized zone segments—connect to two local-area network switches, each with separate power.
- Multiprotocol label switching (MPLS): Head-end circuits are aggregated with AT&T and Verizon in each Connecticut data center and are duplicated in each site.
- Switches in our data center are installed in a redundant manner with respect to node connections.
- Aetna uses Infoblox as our external domain name system (DNS) provider. Redundant Infoblox appliances are implemented in each data center.
- Aetna uses Akamai as a secondary DNS provider for the Aetna.com namespace.

Disaster Recovery Capabilities

Our disaster backup and recovery plan capabilities address a number of factors, including failover protocols, restoration of service timing expectations, and safeguarding confidential information.

Failover Protocols

In the event of an office power outage or natural disaster that impacts a specific location, such as our Charleston office, we will implement our failover protocol and our data processing and related systems will be transferred to an alternate and functioning Aetna office within our network, with little or no service-level disruption. We also rely on a work-at-home capability when necessary. For example, while not impacting West Virginia directly, when Hurricane Harvey struck in August 2017, we invoked our disaster recovery protocols to make it easier for our members to receive Aetna services. Some key protocols included phone tree notifications and mass email; allowing staff to work at home; use of backup resources to augment work-at-home staff for critical functions (member services, prior authorization); collaboration with the

Aetna Facilities department to evaluate the extent of damage and determine the outage period; and collaboration with our IT staff to ensure access to critical systems.

When using alternate temporary offices for business continuity planning purposes, we employ security controls and maintain data backups and redundancies consistent with the main site, which are approved by our security organization. We plan for area-wide disruptions by separating the critical business functions into primary and alternate physical sites situated in different Mountain Health Trust zones. This approach mitigates the risk of losing both sites in an area-wide disruption. We maintain a geographically separate 'hot' or business-ready alternate site for critical business processes and information processing services, which require a recovery time objective within 24 hours and a restart of all remaining operations within three calendar days following a natural or manmade disaster. We deem critical business processes as hot when they are associated with time-sensitive administrative operations or if they are member-facing services (e.g., call center, pharmacy access, and care management functions) that are required to be continually accessible.

Safeguarding Confidential Information

Cybersecurity threats are now ubiquitous, and the diversity of threat actors and tactics in the health care sector has evolved significantly in recent years. With new technologies introduced constantly, our response adaptability and resiliency are critical to safeguarding confidential information. As such, data security has become a cornerstone of Aetna's operating model, influencing how Aetna chooses to do business.

Quarterly, our national Global Security team reviews top cyber risks with Aetna leadership and other stakeholders within our Global Security area. Top risks include stolen passwords, third-party cyber and phishing attacks, ransomware, and a lack of consistent and managed security

controls over cloud services. When needed, our national Security team works with local plan leadership to resolve any of the referenced risks and/or a local data security breach. When applicable, our national Security team shares our cyber risk-related assessment findings and related information with the Department and other plan leadership receive annual cybersecurity training as well as relevant articles, newsletters, and general correspondence.

Disaster Recovery Governance and Corporate Oversight

The Aetna Information Services executive information technology disaster recovery plan (executive plan) is organized and maintained at the enterprise level and is distributed to individual plan leadership. This plan provides the governance for our disaster recovery program and describes the recovery efforts for our data center and its critical components. This plan, which applies to our Mountain Health Trust locations, is derived from over 85 detailed IT infrastructure plans, and is maintained by each critical support function across Aetna. This executive plan, for the purpose of maintaining operations of primary Medicaid IT services throughout a service interruption in our West Virginia sites, includes the following:

- Disaster and recovery-related roles and responsibilities
- Processes and procedures to recover all functions
- Description of the services and equipment, which are needed to recover our data centers

Our DR plans are centrally maintained by our disaster recovery group, stored both locally and off-site, and updated semiannually.

Education and awareness

A key component of Aetna's security program is employee education and awareness of the critical role each plays in protecting Aetna's assets, securing data, and maintaining uninterrupted services for the West Virginia program. Our Mountain Health Trust leadership team stays well-informed about current threats via our shared services communication channels

and receives training on how to validate inquiries for personal data. To ensure our employees and contingent workers are aware and understand the importance of their role in protecting Aetna's information and resources, all Aetna employees, contingent workers, and subcontractors are required to complete annual security awareness and education training.

In addition to employee education, Aetna uses several methods to increase security awareness. These methods include the following:

- Emails: With time- or event-specific information
- AetNet articles (i.e., Aetna's main intranet site)
- Aetna Connect postings (i.e., internal social collaboration tool)
- Learning Center classes, some of which are mandatory across Aetna departments
- Information briefings (e.g., lunch and learn sessions presented by our Aetna Information Sharing and Analysis Center team)
- Digital media boards, which are located at elevator stations and throughout office hallways
- Special events such as the annual information security awareness observance
- Role-based training based on our software security curriculum

Our local Mountain Health Trust plan has benefited from our enterprise-wide data security efforts. Over the past several years, we have substantially reduced our rates of identified security defects and vulnerabilities, from a defect density of over 10 high-severity defects in 10,000 lines of code to approximately 1 per 10,000 lines, representing a 93 percent decrease. Both the effectiveness of our technical controls has increased and the benefits of our application security awareness and local training initiatives have manifested themselves.

Data Protection and Security

Aetna's data security program uses the industry standard National Institute of Standards and Technology (NIST) 800-53 database of security controls and assessment procedures as its control framework and guidance for maintaining solutions to proactively address cyber threats and protect customer data. We use the NIST Critical Security Framework to align our business priorities and security requirements. This security-control environment lays the foundation for

data protection, and our innovative solutions result in a level of protection typically found within the financial industry and other highly regulated environments.

Our identification and remediation of vulnerabilities in IT infrastructure is key to safeguarding confidential information. Our vulnerability management process includes, but is not limited to, the following:

- Monitoring and proactive vulnerability assessments of our external and internal networks
- Continual policy and process improvements
- Subscriptions to threat management systems

Software and Application Patch Management

Software and application patch management is essential to maintaining the integrity and security of systems. Prior to installing any patch to an Aetna system, the recommended update or modification must go through Aetna's change management process, which includes management reviews and documented signoffs. Our change management process accommodates planned, unplanned, and emergency changes. There are generally the following three types of changes that could require modifications to Aetna's systems:

- Major release
- Minor release, which includes service packs, product enhancements, and/or repairs
- Security patches

Aetna requires vendors to communicate major software update releases in advance of the planned release date and to submit a regular schedule for minor software update releases.

For security-related patches, a team of Aetna security engineers monitor external sources for notifications of operating system and application security vulnerabilities. When a patch is announced, our team assesses the patch for risk to Aetna's computing environment. When the primary software vendor releases the patch for the vulnerability, Aetna always obtains the patch from a trusted source.

All security patches are tested prior to being rolled out. Aetna users are notified of patch installation dates as well as the estimated amount of time the installation process will take.

Data Security

Aetna uses the Building Security in Maturity model to measure our organizational practices pertaining to software security against those implemented by some of the most mature software security organizations in the world, including well-known financial institutions and software vendors. We implemented and monitor a series of technical, procedural, and educational controls to help eliminate security defects during software deployment, and we continuously assess production environments to identify and remediate new application vulnerabilities.

We manage our production systems through a role-based access control (RBAC) process. Access to our systems, which are not controlled by RBAC, is approved by designated owners prior to processing the access request. We provision new users, with system access, based on their assigned job code and an associated preapproved RBAC rule set. Users are recertified, according to their RBAC status, twice a year.

Physical Security

Our West Virginia offices, along with all of Aetna, leverage the use of electronic card readers, unique access badges, surveillance cameras, and security guards to promote a strong physical security environment, which is also critical to our approach to safeguarding confidential information. Our servers are housed in secure rooms with limited access. Our manual files are secured in locked file cabinets.

The core component of Aetna's access control system is C-CURE, an industry-leading security application manufactured by Software House, which enables the efficient management of security events through the issuance of ID badges with embedded electronic identification. All staff receive

training on these security protocols as part of our onboarding and other security training courses. This system is monitored on a 24/7/365 basis by the Aetna Corporate Security Operations Center.

Restoration of Service Timing Expectations

Our data center recovery strategy and application recovery time objectives are consistent with broader industry standards. In the event of a core Aetna data center disaster, our recovery time objective to resume the portfolios of universally available applications is immediate and no later than six hours. These applications utilize mirroring and/or load balancing and active-active technologies between our data centers to facilitate our achievement of more aggressive recovery time objectives. Our voice and data networks are redundant; we use synchronous optical networking ring and MPLS to support this redundancy. The recovery time objective for these technologies is within one hour of a data center power outage.

Our recovery time objective to resume most of our production systems, which are not classified as a universally available application, is based on a 3-tier identification of critical Aetna systems with objectives ranging from less than 24 hours to 5 days.

Annual Disaster Recovery Plan Update

We update our DR semiannually and test this plan annually. Our West Virginia Mountain Health plan DR plan tests verify our ability to resume local health plan business operations within 72 hours of the time we activate our DR plan. We regularly and independently test a variety of our applications and infrastructure components to promote ongoing disaster recovery readiness. We also routinely test recovery elements of our third-party relationships, including technology components, critical processes, and their system access points. During our alternate site failover tests, for example, we test our entire network infrastructure, directory services

infrastructure (including authentication and authorization protocols), physical infrastructure, virtual infrastructure, storage infrastructure, and database infrastructure.

Disaster Plan Testing and Testing Frequency

Aetna exceeds the State's annual DR testing frequency requirement because we actively monitor threats to our operations; more frequent testing ensures our DR strategies and practices are always up to date. Nationally, we test our disaster recovery plans during simulation exercises on an ongoing basis, with at least three field-office tests performed annually. We also test these plans during actual events like severe wildfires, floods, hurricanes, and other natural or man-caused disaster events. Following an event, such as when Hurricane Harvey struck in August 2017, we conducted a thorough review of our recovery capabilities, identifying what worked well and opportunities for improvement.

In our most recent test simulating the recovery of our adjudication system, our Medicaid IT team activated their DR plan. This system was fully recovered in less than one day with no performance gaps or issues to report, exceeding the required recovery time objective. Aetna's dedication to be a collaborative and innovative partner with state agencies, members, providers, subcontractors, community-based organizations, and other stakeholders defines us as a loyal organization driving the Department's mission to create a healthier West Virginia. We pride ourselves on being a reliable partner to the Department, especially during times of natural disasters, emergencies, and cybersecurity threats. Our disaster recovery plan ensures our West Virginia-impacted business areas will recover their most critical operations, through timely resource and infrastructure allocations, within their predefined recovery times.

13. Value-Added Services

In addition to the above subject matter areas from ***Appendix 1: Detailed Specifications***, the Vendor should include any Value-Added Services to be offered in this section, as well as any eligibility requirements and potential limits for these services. Vendors are not required to propose value-added benefits, but inclusion of such services may impact the Vendor's overall evaluation. The Vendor's narrative response should not exceed 10 pages.

Value-added Services

Our VAS proposal is categorized into three enrollee-centered groups—those that offer better access to care, those that offer better care to enrollees, and those that offer better support to the communities throughout the State. To improve the quality and impact of these benefits, we are developing our Health Innovation Engine platform to improve our ability to track and monitor eligibility, engagement, effectiveness, and spend for all enrollee value-added services. This proprietary web-based tool, available at contract implementation, streamlines all oversight functions, including the following:

- Addressing health disparities by proactively monitoring under-utilization trends among key at-risk populations
- Preventing fraud, waste, and abuse through benefit design management
- Identifying opportunities to better promote and improve our value-added services
- Measuring benefit impact through enrollee satisfaction, and where applicable, health outcomes

Table 6.13.1-1, Table 6.13.1-2, and **Table 6.13.1-3** provide the descriptions, eligibility criteria, and limits and restrictions of each of our VAS.

Table 6.13.1-1: Aetna Better Access Value-added Services for Managed Care and CHIP Enrollees

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions
Aetna Better Access benefits connect enrollees to services through innovative technology and communication and provide supplies and resources recommended in these services to promote self-care that includes the Keep Kids Safe program, Congestive Heart Failure program reward; Asthma Care program, Pillboxes (seven-day organizer), and our 24-hour Health Information line.

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions

Keep Kids Safe (Opioid Lockbox Program)
West Virginia Need: This is especially needed in West Virginia where we have the eighth highest rate of opioid prescriptions, nationally, according to Centers for Disease Control and Prevention, "U.S. State Prescribing Rates," (2017).
Service: Keep Kids Safe is part of Aetna's national campaign to fight the opioid crisis. This harm-reduction intervention is used to support safety by providing parents, or legal or custodial guardians, with a lockbox to secure their medications. The primary goal is to reduce the number of accidental opioid exposures that could result in poisoning, injury, addiction, or even accidental death. The enrollee and their care manager discuss how to properly use the lockbox to help ensure all prescriptions are properly stored. Enrollees can also contact our Member Services department for information. From our experience, we expect this benefit to positively impact approximately 1,000 enrollees.
Eligibility Criteria: Parents or legal or custodial guardians of enrollees statewide who are prescribed a narcotic, have children in their home, and request a lockbox
Limits and Restrictions: One lockbox per household per lifetime

Congestive Heart Failure Program Reward
West Virginia Need: Weight management is an essential factor for enrollees experiencing congestive heart failure, as weight gain is one of the first signs of a worsening heart. Since heart disease is the leading cause of death in West Virginia, according to Centers for Disease Control and Prevention, "National Center for Health Statistics," (2017), we are committed to helping our enrollees tackle this risk. Enrollees are provided with digital weight scales and a logbook to track weight upon enrollment into the Congestive Heart Failure Program.
Service: Enrollees are encouraged to monitor their weight and to contact their care manager or doctor upon a substantial weight increase (patients can gain up to 10 pounds of extra weight from excess fluid before starting to feel ill or experiencing swelling). This will allow the doctor to review the weight tracking logbook and provide our enrollee with next steps as well as a report protocol to their care manager to help track progress and reduce progression of the condition. From our experience, we expect this benefit to positively impact approximately 300 enrollees.
Eligibility Criteria: Enrollees in case management with a congestive heart failure diagnosis
Limits and Restrictions: One digital weight scale and one weight tracking logbook per member per lifetime

Asthma Care Program
West Virginia Need: According to Centers for Disease Control and Prevention, "Asthma," (2019), West Virginia has the second highest prevalence of adult asthma among all states, and we understand many of our enrollees struggle with this disease.
Service: Our Asthma Care Program was created to support enrollees with asthma and is tailored to each program participating enrollee based on their feedback and progress. It offers three benefits: the first is one-on-one asthma education with one of our certified respiratory therapists; the second is each enrollee who registers in the asthma care program receives a peak flow meter, and the third is a bonus benefit. The following describes each of these value-added services. From our experience, we expect this benefit to positively impact approximately 2,000 enrollees.

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions

Peak Flow Meter: Peak flow meters are used to measure asthma symptoms and ensure the condition is not worsening. Enrollees who register in the Asthma Care Program can take control of their own health through access to their very own peak flow meter.
Eligibility Criteria: Enrollees statewide with an asthma diagnosis
Limits and Restrictions: One peak flow meter per enrollee

Pillboxes (7-day pill organizer)
West Virginia Need: Estimates vary based on the population and the medication, but a reasonable assumption is that 50% of people given a prescription do not take their medication as prescribed. Pill organizers are an effective way to help monitor medication use, and when used properly, any missed doses are obvious, according to Science-Based Medicine, "Do Pill Organizers Help or Hurt?" (2016). A pill organizer will aid our enrollees with their multiple prescriptions and proper dosing and adherence.
Service: Enrollees who register in care management are provided pillboxes to help organize their medications during face-to-face visits with their care manager. This benefit seeks to improve adherence both through encouraging enrollment in care management for enrollees who need it and helping them to organize medications to fit their routine. We expect this benefit to positively impact about 2,000 enrollees.
Eligibility Criteria: All enrollees enrolled in care management
Limits and Restrictions: Limit of two pillboxes per enrollee

24-hour Health Line and Audio Health Library
West Virginia Need: The first assessment of health literacy found that only 10% of American adults are health literacy proficient. Adults most at increased risk for low health literacy include the elderly, minority groups, and those with less than a high school education, according to American Association of Family and Consumer Sciences, Basic Health Literacy (IOM, 2004). Low health literacy predicts a person's health better than age, income, employment status, education level, and race (Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, 1999).
Service: We encourage enrollees to reach out to a licensed health care professional any time 24 hours a day, 7 days a week to help answer specific non-emergency health-related questions on a variety of topics, such as asthma, high blood pressure, alcohol and drug matters, assistance on how to quit smoking, pregnancy, preventive care, and many other topics. Enrollees get advice on what to do when they need health care, such as calling their physician or making an appointment. They also have access to an audio health library that provides more than 300 health, wellness, disease, and medical test topics. Each topic begins with a general description of the condition and provides causes, symptoms, diagnosis, and treatment to empower enrollees to make the best decision for their health-related matters. This benefit has the potential to positively impact all enrollees, as it is available to all enrollees.
Eligibility Criteria: All enrollees statewide
Limits and Restrictions: None

Table 6.13.1-2: Aetna Better Care Value-added Services for Managed Care and CHIP Enrollees

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions
Aetna Better Care offers incentives and health benefits to enrollees to promote responsibility for their health by making healthy choices. We offer a variety of incentives, including gift cards and supplies to help create a healthy home. Our programs include a Comprehensive Diabetes Program, **Good Health Practices, Healthy Pregnancy and Healthy Babies** program, **Moms and Babies** program, **Children's Dental incentive,** and our **Adult Walking** program incentive.
Comprehensive Diabetes Program **West Virginia Need:** Aetna understands how this disease affects our State, which ranks among the top states for morality related to diabetes (at 34/100,000 age-adjusted), according to Centers for Disease Control and Prevention, "National Center for Health Statistics," (2017). Therefore, we have created a comprehensive program focused on diabetic care that consists of several benefits to support them on their journey to improved health. **Service:** Enrollees with Type 2 diabetes can receive routine dental care and a $25 gift card for HbA1c testing, a $25 gift card for completing a diabetic eye exam, and a scholarship to a Camp Kno-Koma. We will also stay engaged with participating enrollees throughout the program via text messaging to provide diabetes-related education for overall improved health and to delay the progression of the disease. From our experience, we expect this benefit to positively impact approximately 1,200 enrollees.
HbA1c Test and Education Incentive: Enrollees receive a $25 gift card for completion of the diabetic education program and completion of HbA1c testing available through our partnership with the Diabetes Collaborative. **Eligibility Criteria:** Enrollees diagnosed with diabetes who reside in one of the following counties (which is tied to a group of specific providers' service areas) where our Diabetes Collaborative partner operates: • Berkeley • Jackson • Monongalia • Roane • Cabell • Jefferson • Morgan • Taylor • Calhoun • Kanawha • Pleasants • Upshur • Gilmer • Lincoln • Preston • Wayne • Grant • Marion • Putnam • Wetzel • Hampshire • Mason • Randolph • Wirt • Harrison • Mineral • Ritchie • Wood **Limits and Restrictions:** Reward is provided for one exam and education session a year per enrollee.
Diabetic Eye Exam Incentive: Enrollees receive a $25 gift card for completion of a diabetic eye exam. **Eligibility Criteria:** Any enrollee with a diabetes diagnosis **Limits and Restrictions:** Reward is provided for one exam a year, per enrollee. The performing provider must submit a qualifying claim for the visit for the enrollee to qualify.

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions

Diabetes Dental: Through our partnership with the West Virginia University School of Dentistry, enrollees diagnosed with Type 2 diabetes can receive routine dental care that includes two exams, two cleanings, and bitewing X-rays each year.
Eligibility Criteria: Enrollees age 21 years old or older with a diagnosis of Type 2 diabetes and must reside in one of the following counties:

- Calhoun
- Gilmer
- Grant
- Hampshire
- Harrison
- Jackson
- Marion
- Mason
- Mineral
- Monongalia
- Pleasants
- Preston
- Randolph
- Ritchie
- Roane
- Taylor
- Upshur
- Wetzel
- Wirt
- Wood

Limits and Restrictions: Once a year for those who are 21 and older with a diabetes Type 2 diagnosis

Camp Scholarship: Enrollees can also receive a scholarship to the historic Camp Kno-Koma, a summer camp for children with diabetes where they can learn in a fun and engaging manner.
Eligibility Criteria: Enrollees age 7 to 15 with a diabetes diagnosis
Limits and Restrictions: One scholarship a year per enrollee

Good Health Practices
West Virginia Need: West Virginia ranks 45th in the nation in overall health and 50th among states with 18.9% indicating frequent mental distress, according to America's Health Rankings, "Annual Report," (2020).
Service: Benefits of well-child visits and preventive care (which includes social behavior/mental health care) means children can get scheduled immunizations to prevent illness and advice on nutrition and safety in the home and at school, while tracking growth and development. This incentive program is designed to encourage enrollees to obtain important preventive services, while emphasizing education, personal responsibility, and ownership of healthy living. Enrollees can receive gift cards by completing certain health preventive activities. We have received feedback from our enrollees about how these incentives encouraged them to take charge of their health through healthy living and being consistent with provider checkups, and we will continue to promote and encourage these benefits. We expect this benefit to positively impact about 3,000 enrollees between the well-child and behavioral health benefits.

$25 Well-child Reward: Enrollees can earn a $25 gift card for completing a well-child exam.
Eligibility Criteria: Enrollees ages 12 to 18 who obtain a well-child exam.
Limits and Restrictions: Enrollee must 12 to 18 years old at the time of visit ; the incentive is given for one visit a year per member; the provider must submit a qualifying claim for the visit for the member to qualify.

Behavioral Health (BH) Follow-up Incentive: To encourage enrollees to stay engaged with their provider, they can earn a $25 gift card for a BH follow-up visit with a mental health practitioner after discharge from an inpatient BH stay for each occurrence.

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions

Eligibility Criteria: BH follow-up visit must occur within seven days after discharge from an inpatient behavioral health stay.
Limits and Restrictions: Qualifying enrollees must be discharged from inpatient BH stay. The provider must submit a qualifying claim for the visit for the member to qualify.

Healthy Pregnancy, Healthy Babies (Prenatal and post-natal preventive care)
West Virginia Need: West Virginia is one of only 6 F-rated states in the March of Dimes most recent report card with a preterm birth rate of 11.8%, according to March of Dimes, "Report Card for West Virginia," (2019). One of the biggest factors positively impacting preterm birth for our enrollees is engaging in consistent prenatal care.
Service: To help encourage early, frequent, and consistent care, we developed this health program for pregnant enrollees and new mothers with incentives to reduce premature births and to support healthy prenatal and post-natal behaviors. We also provide one-on-one help from an Aetna-certified lactation counselor, Text4baby messages to keep mom and baby healthy, and up to two preventive dental visits. This benefit has the potential to positively impact all pregnant enrollees.

Certified Lactation Counselor: Enrollees have access to one-on-one assistance with an Aetna-certified lactation counselor for assistance with breastfeeding training.
Eligibility Criteria: Pregnant enrollees and new moms
Limits and Restrictions: None

Text4baby: A free text messaging service for moms and moms-to-be with tips for a healthy pregnancy and baby. The Text4baby app makes it easy for enrollees to get the critical health and safety information necessary. Additionally, Text4baby will remind enrollees of upcoming appointments.
Eligibility Criteria: Pregnant enrollees and new moms
Limits and Restrictions: None

Pregnancy Dental Care: Pregnant enrollees will receive up to two preventive dental visits including two exams, two cleanings, and bitewing X-rays each year.
Eligibility Criteria: Enrollees who are pregnant
Limits and Restrictions: Two preventive dental visits per pregnancy

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Cribette® (portable crib): Enrollees who complete six prenatal visits with a primary care provider or obstetrician/gynecologist type provider during a single pregnancy will earn a Cribette.
Eligibility Criteria: Pregnant enrollees
Limits and Restrictions: One Cribette per birth

$50 Postpartum Reward: New mothers will earn a $50 gift card after their postpartum visit within 7 to 84 days after giving birth.
Eligibility Criteria: New mothers
Limits and Restrictions: Incentive is for one postpartum exam per enrollee per pregnancy; the provider must submit a qualifying claim for the member to qualify.

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions

Moms and Babies Program (Substance use disorder prevention treatment)
West Virginia Need: West Virginia's neonatal abstinence syndrome (NAS) newborn hospitalization rate (at 56.2 per 1,000) is more than 7 times the national average and has been increasing rapidly for many years (up from 22.1 in 2012), according to Healthcare Cost and Utilization Project, "Neonatal Abstinence Syndrome (NAS) Among Newborn Hospitalizations," (2019).
Service: This program is dedicated to women who have substance abuse disorder during pregnancy. Enrollees who register will receive education, support, and assistance locating treatment. Infants with a NAS diagnosis are paired with a care manager and are followed up for up to one year and can receive a milestone developmental toy after graduation from the program. We expect this benefit to positively impact about 200 enrollees.

Moms and Babies Program Enrollment Reward: Enrollees who register in the program will receive a Cribette or baby carrier upon delivery.
Eligibility Criteria: Pregnant enrollees and new moms with substance abuse disorder
Limits and Restrictions: One Cribette or baby carrier per birth

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Developmental Toy: The baby will receive a lightweight, brightly colored, moveable playcenter that encourages fine motor skills, spatial reasoning, and shape matching on completion of the program.
Eligibility Criteria: Infant enrollees up to one year of age
Limits and Restrictions: One educational toy per infant enrollee

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Children's Dental Incentive
West Virginia Need: About two-thirds of children between one and five years old in West Virginia have never been to the dentist, according to Data Resource Center for Child & Adolescent Health, "NSCH Interactive Data Query," (2018).
Service: Aetna has focused its efforts on this age group and developed an incentive to encourage dental care among children between the ages 2 to 3. Enrollees who complete a dental checkup with a dental practitioner will earn a $25 gift card. We expect this benefit to positively impact about 1,600 enrollees.
Eligibility Criteria: Enrollees ages 2 to 3 years old
Limits and Restrictions: One gift card per enrollee per year. The performing provider must submit a qualifying claim for the visit for the member to qualify.

Adult Walking Program Incentive
West Virginia Need: West Virginia ranks 49th among states on adult obesity and only 29% of adults get any physical activity outside of work, according to Division of Health Promotion and Chronic Disease, "Walking West Virginia," (2020).
Service: Aetna recognizes proper physical activity may be a challenge for many of our enrollees, as we understand the importance of physical activity and its connection to the prevention of chronic disease. Enrollees are encouraged to take charge of their health through our walking program. They will receive a pedometer and logbook for tracking steps upon enrollment in the 8-week program and a $25 gift card for tracking their steps upon completion of the program. We expect this benefit to positively impact about 300 enrollees.

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions
Eligibility Criteria: Adult enrollees age 18 and older who complete the program **Limits and Restrictions:** One pedometer and gift card per enrollee

Table 6.13.1-3: Aetna Better Communities Value-added Services for Managed Care and CHIP Enrollees

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions
Aetna Better Communities empowers our enrollees to better engage with and contribute to their communities by supporting and participating in clubs, events, and self-improvement opportunities. Programs include **Afterschool Program assistance, ATV Safety Class reward, High School Equivalency Diploma Support and Job Skills Training, Hunting and Fishing License for Adults,** and the **Ted E. Bear, M.D.SM Cub Club**.
Afterschool Program Assistance **West Virginia Need:** After-school programs boost academic performance, promote physical health, and provide a safe, structured environment for the children of working parents. For lower-income parents, expense was the second-most-common reason their child did not participate in sports, according to RAND Corporation, "Who Plays, Who Pays?," (2019). **Service:** To support social activity and interaction in addition to school, Aetna is providing $50 toward participation in the statewide West Virginia University Extension/4-H organization (ages 5 to 21) that will provide each participating enrollee access into all the programs offered regardless of ability to pay. Far more than animal husbandry, the 4-H program offers year-round programs and ties directly to school programs around the state offering a feeding program as well as opportunities to learn about science, technology, engineering, and math through fun, hands-on activities, and projects. We expect this benefit to positively impact about 12,000 enrollees. **Eligibility Criteria:** Enrollees statewide ages 5 to 21 who are in enrolled in school and with the consent of the parent or custodial or legal guardian **Limits and Restrictions:** One membership per year per enrollee
ATV Safety Class Reward **West Virginia Need:** West Virginia is ranked the third highest in the nation in reported ATV-related fatalities, according to United States Consumer Product Safety Commission, "Reported ATV-Related Fatalities," (2017). **Service:** While Aetna encourages our enrollees to get outdoors and get active, we want to help them stay safe while having fun. Enrollees who complete a qualified ATV safety course can receive a $25 gift card as a reward. From our experience, we expect this benefit to positively impact approximately 800 enrollees. **Eligibility Criteria:** For enrollees 16 years old and older **Limits and Restrictions:** One gift card per enrollee

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions

High School Equivalency Diploma Support and Job Skills Training
West Virginia Need: At 10%, West Virginia is tied for 16th in the nation for working adults who lack a high school diploma, according to The Annie E. Casey Foundation, "Educational attainment of working age population 25 to 64 in the United States," (2018).
Service: Aetna provides an online General Educational Development (GED) Test Assessing Secondary Completion (TASC) prep course so enrollees can sign up for an online GED/TASC prep course. Once the enrollee passes the GED-TASC online prep course and then passes the State's no-fee TASC test, they receive the State of West Virginia High School Equivalency diploma. Enrollees will also have access to a job skills training platform that is dedicated to health care, information technology markets, and more to discover career paths, earn credentials and certifications, and find local employers actively looking for talent. We expect this benefit to positively impact about 1,800 enrollees.
Eligibility Criteria: Enrollees ages 16 years old and older
Limits and Restrictions: Enrollees who are ages 16 or 17 require parent, custodial, or legal guardian consent; they must have permission from their school district and cannot be registered in another school program.

Back-to-Nature Flu Shot Incentive (Hunting and fishing license for adults or a West Virginia state park gift card [$25])
West Virginia Need: A flu vaccination can reduce the risk of flu-associated hospitalization for children, working age adults, and older adults. Flu vaccine prevents tens of thousands of hospitalizations each year. For example, during 2017-2018, flu vaccination prevented an estimated 91,000 flu-related hospitalizations, according to Centers for Disease Control and Prevention, "What are the benefits of flu vaccination?", Dec. 3, 2019.
Service: Aetna will cover the costs of an annual West Virginia Division of Natural Resources combination hunting/fishing license or a $25 West Virginia State Parks gift card for adult enrollees who receive their annual flu shot. We expect this benefit to positively impact about 1,800 enrollees.
Eligibility Criteria: Enrollees ages 18 years old and older
Limits and Restrictions: One license/renewal/gift card per enrollee per year

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Ted E. Bear, M.D.℠ Cub Club
West Virginia Need: Research has shown that just eating together as a family can improve children's nutritional health. In families who shared at least three meals a week, children were 24% more likely to be eating healthy foods than those in families who ate few or no meals together. The children were also 12% less likely to be overweight, 20% less likely to eat unhealthy foods, and 35% less likely to engage in dangerous weight-loss efforts, according to American Psychological Association, "Healthy Habits for Healthy Families"; revised 2011.
Service: Ted E. Bear, M.D. Cub Club is for enrollees 13 years of age and younger to promote healthy behaviors, healthy habits, and active lifestyles. Each quarter, registered enrollees are encouraged to complete a project/task to improve their overall health and hygiene such as teeth brushing, exercise, or healthy eating. Once completed, the enrollee will receive a reward

Value-added Services: Description, Eligibility Criteria, and Limits and Restrictions

such as a dental hygiene kit, sports ball, fleece blanket, or UV-changing bracelet for sun safety. We expect this benefit to positively impact about 700 enrollees.
Eligibility Criteria: Enrollees statewide 13 years of age and younger
Limits and Restrictions: Enrollees are limited to one reward per quarter based on completed activities.

Aetna Better Health® of West Virginia

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
GE001	1	The Vendor should adhere to page limits, as defined within Section 5 of the Request for Proposal (RFP), and provide responses in 12-point font, single-sided, double-spaced, and with page numbers.	General	All response sections comply with this requirement	All pages
GE002	1	The Vendor should adhere to templates as indicated within the Request for Proposal (RFP) for the provision of all requested information in Attachment 3: Vendor Qualifications & Experience.	General	All applicable response sections comply with this requirement	All pages
BA001	1	The Vendor should provide its plan to impose, monitor, and track member co-pays and quarterly household maximums for including, but not limited to, the following:	Benefit Administration	Attachment 6: Detailed Specifications Approach - Member Co-Pays	Att 6 - Page 80-83
BA002	2	Medical Services (includes Physical, Behavioral Health, Dental, and Vision)	Benefit Administration	Attachment 6: Detailed Specifications Approach - Member Co-Pays	Att 6 - Pages 80-82
BA003	2	Pharmacy Services	Benefit Administration	Attachment 6: Detailed Specifications Approach - Member Co-Pays	Att 6 - Pages 82-83
BA004	1	The Vendor should describe its process for development and revision of Utilization Management (UM) guidelines, as indicated in the Service Provider Agreement (SPA).	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management	Att 6 - Pages 4-9, 35
BA005	1	The Vendor should provide its training curriculum for Utilization Management (UM) and clinical staff.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management	Att 6 - Pages 9-15
BA006	1	The Vendor should describe its Utilization Management (UM) monitoring guidelines that operate in conjunction with fraud and abuse detection activities, including, but not limited to, the following:	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management	Att 6 - Pages 15-26
BA007	2	Ongoing monitoring of Emergency Room (ER) utilization	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management	Att 6 - Page 18
BA008	2	Ongoing monitoring of potential abuse or inappropriate utilization of controlled prescription medications	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management	Att 6 - Pages 19-23

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
BA009	2	Reports and other tools that will be used to monitor and manage service utilization	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management	Att 6 - Pages 23-26, 86
BA010	1	The Vendor should describe its process for preventing and detecting fraud and abuse related to all administered services including Pharmacy, if applicable.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Fraud and Abuse	Att 6 - Pages 45, 83-94
BA011	1	The Vendor should describe its process for modifying its standard Utilization Management (UM) protocols when reviewing referral and treatment requests for members with special health care needs including, but not limited to, the following:	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management for Members with Special Health Care Needs	Att 6 - Pages 26-28
BA012	2	Standing referrals	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management for Members with Special Health Care Needs	Att 6 - Pages 27-28
BA013	2	Expedited utilization review processes	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management for Members with Special Health Care Needs	Att 6 - Page 28
BA014	1	The Vendor should describe its process for any condition-specific protocols or standards that will be used to manage members with special health care needs, defined as individuals with complex or serious medical conditions.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management for Members with Special Health Care Needs	Att 6 - Pages 28-30
BA015	1	The Vendor should describe its process for how condition-specific protocols and conditions will be updated and shared with primary and specialty care providers.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Utilization Management for Members with Special Health Care Needs	Att 6 - Pages 30-31

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
BA016	1	The Vendor should describe its process to honor authorization approvals from previous coverage during the transition period, defined as the period in which members are moving from one Managed Care Organization (MCO) to another or from Fee-for-Service (FFS) to an MCO, or private insurance to an MCO. These processes should include, but are not limited to, the following:	Benefit Administration	Attachment 6: Detailed Specifications Approach - Prior Authorization	Att 6 - Pages 31-34
BA017	2	Medical Services (includes Physical, Behavioral Health, Dental, and Vision)	Benefit Administration	Attachment 6: Detailed Specifications Approach - Prior Authorization	Att 6 - Pages 31-33
BA018	2	Pharmacy	Benefit Administration	Attachment 6: Detailed Specifications Approach - Prior Authorization	Att 6 - Pages 31, 33-34
BA019	1	The Vendor should describe how providers and/or members will be notified regarding the expiration of medical authorizations, and pharmacy authorizations, if applicable.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Prior Authorization	Att 6 - Page 34
BA020	1	The Vendor should describe its process for authorizing out-of-network access including, but not limited to, the following:	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Pages 41-45
BA021	2	Emergency Services, including transportation	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Page 43
BA022	2	Medically Necessary Travel, for the West Virginia Children's Health Insurance Program (WVCHIP)	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Pages 43-44
BA023	2	Medical Necessity	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Pages 44-45
BA024	2	Out-of-State Providers (for example, members who are students, live in proximity to State borders, etc.)	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Page 45
BA025	1	The Vendor should describe its process for circumstances under which a member might be granted a standing referral to a specialist provider.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Page 53
BA026	1	The Vendor should describe the extent to which a specialist provider may refer services.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Pages 53-54

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
BA027	1	The Vendor should describe its process for out-of-network referrals, including, but not limited to, the following:	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Pages 45-47
BA028	2	Members and/or providers requesting out-of-network referrals	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Page 47
BA029	2	Processes in which a member may continue an existing relationship with an out-of-network provider, or a provider that leaves the Vendor's network, if considered to be in the best medical interest of the member	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Page 48
BA030	2	Durations permitted for members to see out-of-network providers that refuse to contract with the Vendor for ongoing courses of treatment past the first 90 days of enrollment	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Page 42, 48
BA031	1	The Vendor should its procedures for ensuring that member information from non-network providers is shared with the member's Primary Care Provider (PCP).	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Pages 48-50
BA032	1	The Vendor should describe its process to assist in enrolling and pairing the member with an appropriate in-network provider within 90 days of enrollment.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Pages 50-51
BA033	1	The Vendor should describe its process for transferring necessary clinical information to a member's new provider.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Access to Care	Att 6 - Pages 51-53
BA034	1	The Vendor should describe its process for member access and coverage of Family Planning services.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Family Planning	Att 6 - Pages 66-69
BA035	1	The Vendor should describe its process for accessing crisis stabilization services.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Crisis Stabilization	Att 6 - Pages 69-72
BA036	1	The Vendor should describe how they will comply with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program requirements, as indicated by the Centers for Medicare & Medicaid Services (CMS) at https://www.medicaid.gov/medicaid/benefits/epsdt/index.html, including its process to ensure that children who are receiving primary care from a specialist receive EPSDT services.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Early and Periodic Screening, Diagnosis, and Treatment	Att 6 - Pages 72-79

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Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
BA037	1	The Vendor should describe its policies and procedures for assisting the State or fiscal agent with the pharmacy rebate resolution process including rejected or disputed physician administered drug claims.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Pharmacy Rebate Resolution	Att 6 - Pages 94-99
BA038	1	The Vendor should describe its policies and procedures that outline how cases of medical necessity will be handled when medical service limitations are imposed.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Medical Necessity	Att 6 - Pages 35-37
BA039	1	The Vendor should describe its policies and procedures that outline how cases of medical necessity will be handled when prescription limits are imposed.	Benefit Administration	Attachment 6: Detailed Specifications Approach - Medical Necessity	Att 6 - Pages 38-41
BA040	1	The Vendor should describe its process for informing Primary Care Providers (PCPs) regarding changes in a member's behavioral health status including, but not limited to, the following:	Benefit Administration	Attachment 6: Detailed Specifications Approach - Coordination of Care	Att 6 - Pages 63-66
BA041	2	What constitutes a change in behavioral health status	Benefit Administration	Attachment 6: Detailed Specifications Approach - Coordination of Care	Att 6 - Pages 64-65
BA042	2	How the member will be assisted to access additional services as a result of a change in behavioral health status	Benefit Administration	Attachment 6: Detailed Specifications Approach - Coordination of Care	Att 6 - Pages 65-66
BA043	1	The Vendor should describe its coordination of care activities between Primary Care Providers (PCPs) and children's dental providers, especially for children with special health care needs (CSHCN).	Benefit Administration	Attachment 6: Detailed Specifications Approach - Coordination of Care	Att 6 - Page 66
BA044	1	The Vendor should describe its mechanisms to remind members of upcoming appointments, including, but not limited to, the following:	Benefit Administration	Attachment 6: Detailed Specifications Approach - Coordination of Care	Att 6 - Page 56-63
BA045	2	Medical Appointments and Screenings	Benefit Administration	Attachment 6: Detailed Specifications Approach - Coordination of Care	Att 6 - Pages 56-58
BA046	2	Dental Appointments and Screenings, including monitoring utilization and interventions if a member has not had a screening in over one year	Benefit Administration	Attachment 6: Detailed Specifications Approach - Coordination of Care	Att 6 - Pages 58-62

Att 6 - Page 700

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
BA047	2	Adherence to the periodicity schedule as dictated by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, as indicated by the Centers for Medicare & Medicaid Services (CMS) at https://www.medicaid.gov/medicaid/benefits/epsdt/index.html	Benefit Administration	Attachment 6: Detailed Specifications Approach - Coordination of Care	Att 6 - Pages 62-63
CM001	1	The Vendor should describe its Care Management program, including, but not limited to, the following:	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 121-157
CM002	2	Processes to organize its care management department by disease or problem type	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 123-125
CM003	2	Processes to identify members for participation in the care management program, including screening and timeliness of enrollment, risk levels/tiers, Social Determinants of Health (SDOH)	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages: 125-127, 129-134, 135-138
CM004	2	Processes and timeframes for assigning members to a care manager	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 125-127, 138-139
CM005	2	Processes for identifying candidates for care management, or those receiving high-cost care, who would benefit from care management	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 125-129, 132-135
CM006	2	Processes for how care managers will establish relationships with members, including frequency and timeliness standards after the initial health assessment	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 135-138, 139-140

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Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CM007	2	Processes to ensure that members who have specialists as Primary Care Providers (PCPs) are receiving primary care services on an ongoing basis, and interventions if adequate services are not being provided	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 143
CM008	2	Processes to ensure continuity and coordination of care	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 141-143
CM009	2	Processes to identify pregnant women at enrollment and on an ongoing basis	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 143-144
CM010	2	Processes to promote "early and often" prenatal care for women identified as being pregnant	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 143-149
CM011	2	Processes for Supplemental Security Income (SSI) members, if different	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 143, 149-150
CM012	2	Processes for administering care management for both adults and children	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 143, 150-154
CM013	2	Processes for administering care management for members with special health care needs, defined as individuals with complex or serious medical conditions	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 143, 154-155

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CM014	2	Processes for administering care management for children with special health care needs (CSHCN)	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 155-156
CM015	1	The Vendor should describe strategies to manage members with a history of prescription drug abuse, and processes for monitoring potential abuse or inappropriate utilization of controlled prescription medications.	Care Management	Attachment 6: Detailed Specifications Approach - Addressing Prescription Drug Abuse	Att 6 - Pages 196-210
CM016	1	The Vendor should describe its process for performing screenings or assessments as part of its care management program, including, but not limited to, the following:	Care Management	Attachment 6: Detailed Specifications Approach - Screening, Assessment, and Education	Att 6 - Pages 157-160
CM017	2	Members with special health care needs, defined as individuals with complex or serious medical conditions	Care Management	Attachment 6: Detailed Specifications Approach - Screening, Assessment, and Education	Att 6 - Pages 157-163
CM018	2	Children with special health care needs (CSHCN)	Care Management	Attachment 6: Detailed Specifications Approach - Screening, Assessment, and Education	Att 6 - Pages 157-163
CM019	2	Clinical, social, or other criteria used to determine which members require care management and assignment to care managers	Care Management	Attachment 6: Detailed Specifications Approach - Addressing Prescription Drug Abuse; Screening, Assessment, and Education	Att 6 - Pages 135, 157-160
CM020	2	Performance of health assessments	Care Management	Attachment 6: Detailed Specifications Approach - Screening, Assessment, and Education	Att 6 - Pages 160-163
CM021	2	Implementation of targeted education programs	Care Management	Attachment 6: Detailed Specifications Approach - Screening, Assessment, and Education	Att 6 - Pages 164-166

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CM022	1	The Vendor should describe its process for creating educational materials and educating members and care management staff.	Care Management	Attachment 6: Detailed Specifications Approach - Screening, Assessment, and Education	Att 6 - Pages 164-168
CM023	1	The Vendor should describe its staff qualification and training requirements for individuals who will be involved in coordinating care, including, but not limited to, any specialized care managers utilized for certain conditions.	Care Management	Attachment 6: Detailed Specifications Approach - Local Care Management Staff Infrastructure	Att 6 - Pages 105-114
CM024	1	The Vendor should describe its process for hiring care management staff including, but not limited to, the following:	Care Management	Attachment 6: Detailed Specifications Approach - Local Care Management Staff Infrastructure	Att 6 - Pages 114-115
CM025	2	Staff qualifications	Care Management	Attachment 6: Detailed Specifications Approach - Local Care Management Staff Infrastructure	Att 6 - Pages 108-114
CM026	2	Plan for hiring	Care Management	Attachment 6: Detailed Specifications Approach - Local Care Management Staff Infrastructure	Att 6 - Pages 105-115
CM027	2	Timeframe for hiring	Care Management	Attachment 6: Detailed Specifications Approach - Local Care Management Staff Infrastructure	Att 6 - Pages 114-115
CM028	2	Total number of care managers to be hired	Care Management	Attachment 6: Detailed Specifications Approach - Local Care Management Staff Infrastructure	Att 6 - Pages 114-115
CM029	2	Maximum case loads and ratios per care manager for Vendor-defined risk tiers	Care Management	Attachment 6: Detailed Specifications Approach - Local Care Management Staff Infrastructure	Att 6 - Pages 114-115

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CM030	1	The Vendor should describe its process for monitoring and evaluating care managers in regard to establishing relationships with members, including, but not limited to, statistics collected and frequency of collection.	Care Management	Attachment 6: Detailed Specifications Approach - Local Care Management Staff Infrastructure	Att 6 - Pages 116-121
CM031	1	The Vendor should describe its protocols for addressing a member that would benefit from a care manager, including alternatives for members that do not want a care manager, members who cannot be reached, and members who have missed medical appointments.	Care Management	Attachment 6: Detailed Specifications Approach - Care Management Processes and Member Identification Overview	Att 6 - Pages 156-157
CM032	1	The Vendor should describe its process for identifying members in need of treatment plans, and the development, updating, and implementation of treatment plans wherein service coordination is required.	Care Management	Attachment 6: Detailed Specifications Approach - Care Planning	Att 6 - Pages 168-173
CM033	1	The Vendor should describe its process for the development of member treatment plans, including, but not limited to, the following:	Care Management	Attachment 6: Detailed Specifications Approach - Care Planning	Att 6 - Pages 168-182
CM034	2	Including Primary Care Providers (PCPs) in the development of treatment plans	Care Management	Attachment 6: Detailed Specifications Approach - Care Planning	Att 6 - Pages 168-174
CM035	2	Sharing treatment plans with the member's PCP or other providers, as applicable	Care Management	Attachment 6: Detailed Specifications Approach - Care Planning	Att 6 - Pages 168-174
CM036	2	Staff responsible for sharing treatment plans with the member's PCP	Care Management	Attachment 6: Detailed Specifications Approach - Care Planning	Att 6 - Page 174
CM037	2	Tracking of completion of treatment plans	Care Management	Attachment 6: Detailed Specifications Approach - Care Planning	Att 6 - Page 174
CM038	2	Identification, tracking, and remediation of gaps in care	Care Management	Attachment 6: Detailed Specifications Approach - Care Planning	Att 6 - Pages 175-177
CM039	2	Processes for episodic and/or catastrophic care management interventions	Care Management	Attachment 6: Detailed Specifications Approach - Care Planning	Att 6 - Pages 177-182

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CM040	1	The Vendor should describe its protocols for addressing a provider that does not perform coordination activities that includes, but is not limited to, the following:	Care Management	Attachment 6: Detailed Specifications Approach - Special Care Coordination Circumstances	Att 6 - Pages 192-193
CM041	2	Identification	Care Management	Attachment 6: Detailed Specifications Approach - Special Care Coordination Circumstances	Att 6 - Pages 192-193
CM042	2	Actions taken to improve coordination	Care Management	Attachment 6: Detailed Specifications Approach - Special Care Coordination Circumstances	Att 6 - Pages 192-193
CM043	1	The Vendor should describe its programs for coordination of care with community resources and social services for members.	Care Management	Attachment 6: Detailed Specifications Approach - Special Care Coordination Circumstances	Att 6 - Page 193
CM044	1	The Vendor should describe its approach to address Social Determinants of Health (SDOH).	Care Management	Attachment 6: Detailed Specifications Approach - Social Determinants of Health	Att 6 - Pages 182-191
CM045	1	The Vendor should describe its care coordination efforts that identify and address member access including, but not limited to, the following:	Care Management	Attachment 6: Detailed Specifications Approach - Social Determinants of Health	Att 6 - Pages 182-191
CM046	2	Employment	Care Management	Attachment 6: Detailed Specifications Approach - Social Determinants of Health	Att 6 - Pages 185-191
CM047	2	Food security	Care Management	Attachment 6: Detailed Specifications Approach - Social Determinants of Health	Att 6 - Pages 185-191
CM048	2	Housing stability	Care Management	Attachment 6: Detailed Specifications Approach - Social Determinants of Health	Att 6 - Pages 185-191
CM049	2	Education	Care Management	Attachment 6: Detailed Specifications Approach - Social Determinants of Health	Att 6 - Pages 185-191
CM050	2	Social cohesion	Care Management	Attachment 6: Detailed Specifications Approach - Social Determinants of Health	Att 6 - Pages 185-191

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CM051	2	Resources that connect members to social supports and healthcare	Care Management	Attachment 6: Detailed Specifications Approach - Social Determinants of Health	Att 6 - Pages 185-191
CM052	2	Environmental needs	Care Management	Attachment 6: Detailed Specifications Approach - Social Determinants of Health	Att 6 - Pages 185-191
CM053	1	The Vendor should describe its plan to develop additional programs for Social Determinants of Health (SDOH).	Care Management	Attachment 6: Detailed Specifications Approach - Social Determinants of Health	Att 6 - Pages 191
CM054	1	The Vendor should describe its population health approach including, but not limited to, the following:	Care Management	Attachment 6: Detailed Specifications Approach - Approach to Population Health	Att 6 - Pages 210-216
CM055	2	Engaging members across the entire care continuum	Care Management	Attachment 6: Detailed Specifications Approach - Approach to Population Health	Att 6 - Pages 211-212
CM056	2	Promoting and incentivizing healthy behaviors and disease self-management	Care Management	Attachment 6: Detailed Specifications Approach - Approach to Population Health	Att 6 - Pages 212-214
CM057	2	Integrating care management	Care Management	Attachment 6: Detailed Specifications Approach - Approach to Population Health	Att 6 - Pages 214-215
CM058	2	Advancing evidence-based practices	Care Management	Attachment 6: Detailed Specifications Approach - Approach to Population Health	Att 6 - Pages 215-216
CM059	1	The Vendor should describe its process to evaluate the member population and coordinate prevention and wellness programs available to all members.	Care Management	Attachment 6: Detailed Specifications Approach - Approach to Population Health	Att 6 - Pages 216-219
CM060	1	The Vendor should describe its process to collect and maintain member self-reported demographic, social determinants, and health needs assessment data for aggregate use in, at a minimum, population health management, network adequacy determination, and quality improvement activities.	Care Management	Attachment 6: Detailed Specifications Approach - Approach to Population Health	Att 6 - Pages 219-223

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CM061	1	The Vendor should describe its process to refer all eligible pregnant members to the Bureau for Public Health's (BPH's) Women, Infants, and Children Program (WIC) for nutrition services during and after pregnancy.	Care Management	Attachment 6: Detailed Specifications Approach - Special Care Coordination Circumstances	Att 6 - Pages 193-194
CM062	1	The Vendor should describe its process to coordinate with the Bureau for Public Health's (BPH's) Office of Maternal, Child, and Family Health (OMCFH), Office of Nutrition Services (ONS), and Office of Community Health Systems and Health Promotion (OCHSHP) to link members with necessary public health prevention and support services.	Care Management	Attachment 6: Detailed Specifications Approach - Special Care Coordination Circumstances	Att 6 - Pages 193-195
CM063	1	The Vendor should describe its protocols to coordinate care for members receiving Social Necessary Services (SNS) through the Specialized Foster Care Administrative Services Organization (ASO).	Care Management	Attachment 6: Detailed Specifications Approach - Special Care Coordination Circumstances	Att 6 - Pages 195
CM064	1	The Vendor should describe its process to share information for children enrolled in the Specialized Foster Care Managed Care Organization (MCO) including, but not limited to, authorization data, medical history, claims history, medical records, and other patient information.	Care Management	Attachment 6: Detailed Specifications Approach - Special Care Coordination Circumstances	Att 6 - Pages 195-196
CS001	1	The Vendor should describe its approach to establishing and maintaining relationships with associated Department agencies and State advocacy groups.	Community/Stakeholder Engagement	Attachment 6: Detailed Specifications Approach - Collaborative Approach to Department Agencies and State Advocacy Groups	Att 6 - Pages 228-235
CS002	1	The Vendor should describe its approach to establishing and maintaining relationships with applicable provider and medical associations.	Community/Stakeholder Engagement	Attachment 6: Detailed Specifications Approach - Approach to Establishing and Maintaining Relationships with Provider and Medical Associations	Att 6 - Pages 235-238
CS003	1	The Vendor should describe its approach to establishing and maintaining relationships with applicable professional boards.	Community/Stakeholder Engagement	Attachment 6: Detailed Specifications Approach - Approaching and Establishing Relationships with Professional Boards	Att 6 - Pages 238-239

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CS004	1	The Vendor should describe its process to coordinate with agencies providing complimentary services to the member.	Community/Stakeholder Engagement	Attachment 6: Detailed Specifications Approach - Coordinating Agencies to Provide Complimentary Services to Members	Att 6 - Pages 239-248
MS001	1	The Vendor should describe how they will collaborate with stakeholders to design materials that best meet the needs of the populations being served.	Member Services	Attachment 6: Detailed Specifications Approach - Health Education Programs	Att 6 - Pages 308-328
MS002	1	The Vendor should describe how they will leverage information technology (IT) solutions to improve access to member information.	Member Services	Attachment 6: Detailed Specifications Approach - Member Assessment	Att 6 - Pages 297-298
MS003	1	The Vendor should describe its methodology for assigning members to a Primary Care Provider (PCP) including, but not limited to, claims history, proximity, and within contractually defined timeframe.	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 261-263
MS004	1	The Vendor should describe how they will develop protocols to notify members of Primary Care Provider (PCP) assignment.	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 263-264
MS005	1	The Vendor should describe how they will educate members of the right to change Primary Care Providers (PCPs).	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Page 264
MS006	1	The Vendor should describe its process for conducting initial and ongoing assessments appropriate for members' circumstances and needs including, but not limited to, the following:	Member Services	Attachment 6: Detailed Specifications Approach - Member Assessment	Att 6 - Pages 282-288
MS007	2	Methods utilized to complete assessments, and variances by risk level	Member Services	Attachment 6: Detailed Specifications Approach - Member Assessment	Att 6 - Pages 282-289
MS008	2	Timeline to complete assessments, and variances by risk level	Member Services	Attachment 6: Detailed Specifications Approach - Member Assessment	Att 6 - Pages 282-287
MS009	2	Identification of the trigger(s) for completion of a comprehensive assessment	Member Services	Attachment 6: Detailed Specifications Approach - Member Assessment	Att 6 - Pages 287-291
MS010	2	How assessments will be used to develop and update treatment plans and confirm the risk stratification level for each member	Member Services	Attachment 6: Detailed Specifications Approach - Member Assessment	Att 6 - Pages 295-296

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
MS011	2	How data from a member's Primary Care Provider (PCP) will be used to prevent duplication of assessment efforts and assist with identification of priorities for the member	Member Services	Attachment 6: Detailed Specifications Approach - Member Assessment	Att 6 - Pages 291-292
MS012	2	How a member who cannot be reached or who refuse assessments will be handled by the Vendor, including multiple contacts if initial contacts are unsuccessful	Member Services	Attachment 6: Detailed Specifications Approach - Member Assessment	Att 6 - Pages 292-295
MS013	2	How assessment data will be stored and made available to members of the care team in order to coordinate care	Member Services	Attachment 6: Detailed Specifications Approach - Member Assessment	Att 6 - Pages 296-297
MS014	2	How assessment data will be shared with a member's other payer(s), as applicable, in order to prevent duplication of efforts	Member Services	Attachment 6: Detailed Specifications Approach - Member Assessment	Att 6 - Page 297
MS015	1	The Vendor should describe how they will distribute and provide notice of member handbooks on an ongoing basis, according to an established turnaround time, and including, but not limited to, the following:	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 260-261
MS016	2	Updates to the member handbook	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 260-261
MS017	2	Handbooks requested ad hoc by a member	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 260-261
MS018	1	The Vendor should describe its warm transfer protocols for its member services, other internal departments, other entities, and subcontractors, as applicable.	Member Services	Attachment 6: Detailed Specifications Approach - Member Services Call Center	Att 6 - Pages 328-337
MS019	1	The Vendor should describe how they will train member services representatives.	Member Services	Attachment 6: Detailed Specifications Approach - Member Services Call Center	Att 6 - Pages 337-342
MS020	1	The Vendor should describe how they will ensure they are meeting customer use and report to the Department on customer service performance standards including, but not limited to, the following:	Member Services	Attachment 6: Detailed Specifications Approach - Member Rights; Member Services Call Center	Att 6 - Pages 278-280, 343-346
MS021	2	Member-to-representative ratios	Member Services	Attachment 6: Detailed Specifications Approach - Member Services Call Center	Att 6 - Page 338

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MS022	2	Call answering time, with a minimum of 83% of calls answered in thirty (30) seconds	Member Services	Attachment 6: Detailed Specifications Approach - Member Services Call Center	Att 6 - Pages 343-346
MS023	2	Call abandonment rate not to exceed five percent (5%)	Member Services	Attachment 6: Detailed Specifications Approach - Member Services Call Center	Att 6 - Pages 343-346
MS024	2	Single contact resolution	Member Services	Attachment 6: Detailed Specifications Approach - Member Services Call Center	Att 6 - Pages 343-346, 333
MS025	2	Turnaround time for member requests	Member Services	Attachment 6: Detailed Specifications Approach - Member Services Call Center	Att 6 - Pages 273-280, 333, 343-346
MS026	2	Remediation strategies for performance issues	Member Services	Attachment 6: Detailed Specifications Approach - Member Services Call Center	Att 6 - Pages 345
MS027	1	The Vendor should describe its new member enrollment and education process, defined as the time of initial notification of the member's enrollment through the first month of actual enrollment, which includes, but is not limited to, the following:	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 253-261
MS028	2	Member contact, including welcome calls, welcome letters, and/or home visits	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 253-255
MS029	2	Outreach to members who are difficult to contact, including disabled members and members without telephones	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 255-257
MS030	2	Processing and issuing identification cards	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 257-259
MS031	2	Distributing member handbooks	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 260-261

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MS032	1	The Vendor should describe how they will make information available for members who have Limited English Proficiency (LEP) or limited reading skills, as indicated per 67 Federal Regulation (FR) 41455 (https://www.govinfo.gov/content/pkg/FR-2002-06-18/pdf/02-15207.pdf).	Member Services	Attachment 6: Detailed Specifications Approach - Member Rights, Member Services Call Center, and Table 6.5.1-2	Att 6 - Pages 266-271, 303, 341
MS033	1	The Vendor should describe how they will provide a secure member portal that allows members to log in and access benefit information including, but not limited to, the following:	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 264-265
MS034	2	Medical records	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 264-265
MS035	2	Authorization status	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 264-265
MS036	2	Cost sharing information	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 264-265
MS037	2	Temporary identification (ID) cards	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 264-265
MS038	2	Confirmation of Primary Care Provider (PCP)	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 264-265
MS039	2	Provision of access to guardians	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 264-265
MS040	1	The Vendor should describe its process to inform members that program information is available in paper form without charge upon request and available within five (5) business days.	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment, Member Rights	Att 6 - Pages 267, 271, 322

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
MS041	1	The Vendor should describe how they will make auxiliary aids and services, as well as oral interpretation services, available in all non-English languages to all members and potential members, free of charge, including the top fifteen languages spoken in the State, which are Spanish, Chinese, French, German, Arabic, Vietnamese, Korean, Japanese, Tagalog, Italian, Thai, Nepali, Persian, Russian, and Urdu.	Member Services	Attachment 6: Detailed Specifications Approach - Member Rights	Att 6 - Pages 257, 260, 267, 271-272, 275, 303
MS042	1	The Vendor should describe how they will notify members that oral interpretation services are available for any language, and that written information is available in prevalent languages and braille, and how to access those services.	Member Services	Attachment 6: Detailed Specifications Approach - Member Rights	Att 6 - Pages 260, 266-273, 300, 341
MS043	1	The Vendor should describe how they will include taglines in all written materials in the prevalent non-English languages and large print (in a font size no smaller than eighteen [18] point) explaining the availability of written translation or oral interpretation and the toll-free and Text Telephone (TTY)/Telecommunication Device for the Deaf (TDD) telephone number of the Vendor.	Member Services	Attachment 6: Detailed Specifications Approach - Member Rights	Att 6 - Pages 251-254, 260, 267, 269, 272, 322, 324
MS044	1	The Vendor should describe its policies and procedures related to issuance of member identification cards within contractually defined timeframes.	Member Services	Attachment 6: Detailed Specifications Approach - New Member and Member Enrollment	Att 6 - Pages 251-253, 259-260
MS045	1	The Vendor should describe how they will administer a health education program for disease and injury prevention and identification.	Member Services	Attachment 6: Detailed Specifications Approach - Health Education Programs	Att 6 - Pages 309-312
MS046	1	The Vendor should describe its tobacco-cessation program.	Member Services	Attachment 6: Detailed Specifications Approach - Health Education Programs	Att 6 - Pages 327-328
MS047	1	The Vendor should describe how they will leverage community events/resources to help improve the health of its member population.	Member Services	Attachment 6: Detailed Specifications Approach - Health Education Programs	Att 6 - Page 312-317
MS048	1	The Vendor should describe how they will foster cultural competency among staff.	Member Services	Attachment 6: Detailed Specifications Approach - Cultural Competency	Att 6 - Pages 298-307

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
ED001	1	The Vendor should describe its policies and procedures regarding enrollment of members, including the processing of 834 enrollment files.	Enrollment and Disenrollment	Attachment 6: Detailed Specifications Approach - Policies and Procedures Regarding Member Enrollment	Att 6 - Pages 347-359
ED002	1	The Vendor should describe its policies and procedures regarding disenrollment of members, including processes for reconciliation of members against the monthly 820 capitation file.	Enrollment and Disenrollment	Attachment 6: Detailed Specifications Approach - Policies and Procedures Regarding Member Disenrollment	Att 6 - Pages 360-362
ED003	1	The Vendor should describe its written policies and procedures and protocols for enrolling newborn children of members retroactively to the time of birth, and transferring newborn information to the Department for processing.	Enrollment and Disenrollment	Attachment 6: Detailed Specifications Approach - Policies and Procedures for Retroactively Enrolling Newborn Children	Att 6 - Pages 363-365
ED004	1	The Vendor should describe its protocols to cover newborns even if the mother does not remain enrolled after the newborn's date of birth.	Enrollment and Disenrollment	Attachment 6: Detailed Specifications Approach - Newborn Coverage Protocol When Mother is no longer Enrolled	Att 6 - Pages 366-367
ED005	1	The Vendor should describe its written policies and procedures for transferring relevant member information, including medical records and other pertinent materials, when a member is disenrolled from the Vendor and enrolled with another Vendor.	Enrollment and Disenrollment	Attachment 6: Detailed Specifications Approach -	Att 6 - Pages 367-371
ND001	1	The Vendor should describe how they will establish and maintain a provider network that provides statewide access to geographically accessible hospitals, primary care, specialty care, dental providers, and all other required provider types and specialties.	Network Development	Attachment 6: Detailed Specifications Approach - Establishing and Maintaining a Provider Network	Att 6 - Pages 372-382
ND002	1	The Vendor should describe how they will establish and maintain a network of accessible, contracted, and credentialed providers for all covered services including supplemental services such as value-add services for, or on behalf of Mountain Health Trust (MHT) members.	Network Development	Attachment 6: Detailed Specifications Approach - Establishing and Maintaining a Provider Network	Att 6 - Pages 372-373, 382-383,

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
ND003	1	The Vendor should describe how they will establish network development and monitoring processes that ensure adequacy of covered services and includes the following considerations, including, but not limited to, the following:	Network Development	Attachment 6: Detailed Specifications Approach - Network Development and Monitoring Processes to Ensure Adequacy	Att 6 - Pages 383-391
ND004	2	The anticipated MHT enrollment and the appropriate PCP provider-to-member ratios for adult and pediatric members	Network Development	Attachment 6: Detailed Specifications Approach - Network Development and Monitoring Processes to Ensure Adequacy	Att 6 - Pages 390
ND005	2	The expected utilization of services for the anticipated MHT populations assigned to the Vendor for care	Network Development	Attachment 6: Detailed Specifications Approach - Network Development and Monitoring Processes to Ensure Adequacy	Att 6 - Pages 390-391
ND006	2	The number of providers not accepting new patients	Network Development	Attachment 6: Detailed Specifications Approach - Network Development and Monitoring Processes to Ensure Adequacy	Att 6 - Pages 391
ND007	2	The geographic location of providers and members, considering time and distance, and transportation needs	Network Development	Attachment 6: Detailed Specifications Approach - Network Development and Monitoring Processes to Ensure Adequacy	Att 6 - Pages 391-392
ND008	2	The location of providers with physical access accommodations for members with disabilities and/or other requirements set forth under the Americans with Disabilities Act (ADA)	Network Development	Attachment 6: Detailed Specifications Approach - Network Development and Monitoring Processes to Ensure Adequacy	Att 6 - Pages 392-393
ND009	1	The Vendor should describe how they ensure its provider network will provide culturally competent care to members.	Network Development	Attachment 6: Detailed Specifications Approach - Cultural Competency	Att 6 - Pages 393-396
ND010	1	The Vendor should describe how they will develop and maintain a directory of providers that includes provider names, locations with street address, website URLs (as appropriate), and telephone numbers of current contracted providers in the member's service area.	Network Development	Attachment 6: Detailed Specifications Approach - Provider Directory	Att 6 - Pages 396-398

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
ND011	1	The Vendor should describe its process to ensure its provider network adheres to geographical access standards for all adult and pediatric members.	Network Development	Attachment 6: Detailed Specifications Approach - Geographical Access Standards	Att 6 - Page 398
ND012	1	The Vendor should describe how they will establish provider contracts and include in its provider network all identified comprehensive behavioral health and Psychiatric Residential Treatment Facilities (PRTF), as defined within the Service Provider Agreement (SPA), for both pediatric and adult Mountain Health Trust (MHT) members.	Network Development	Attachment 6: Detailed Specifications Approach - Comprehensive Behavioral Health Provider Network	Att 6 - Pages 398-399
ND013	1	The Vendor should describe how its network development and adequacy processes include and assess provider hours of operations, convenience to members, and parity to commercial or Fee-for-Service (FFS) populations.	Network Development	Attachment 6: Detailed Specifications Approach - Provider Hours of Operation, Member Convenience and Parity	Att 6 - Pages 399-400
ND014	1	The Vendor should describe its guidelines and monitoring processes that ensure members have timely access to care per contractual requirements.	Network Development	Attachment 6: Detailed Specifications Approach - Access to Care Guidelines and Monitoring	Att 6 - Pages 400-401
ND015	1	The Vendor should describe its process for the selection, credentialing, retention, and maintaining of qualified providers.	Network Development	Attachment 6: Detailed Specifications Approach - Selection, Credentialing, Retention, Maintenance	Att 6 - Pages 401-410
ND016	1	The Vendor should describe how they will ensure that its network providers have completed enrollment with the Department as required by Centers for Medicare & Medicaid Services (CMS) Medicaid and Children's Health Insurance Program Medicaid Managed Care Final Rule (https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered).	Network Development	Attachment 6: Detailed Specifications Approach - Provider Enrollment with Department	Att 6 - Page 415-416

Att 6 - Page 716

Att 6 - Page 717

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
ND017	1	The Vendor should describe how they will establish credentialing and re-credentialing processes that fully comply with West Virginia C.S.R. §114-53-6 (https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/rule_053.pdf?ver=2004-09-14-092000-000) and 42 Code of Federal Regulations (CFR) 455, Subpart B (https://www.govinfo.gov/app/details/CFR-2011-title42-vol4/CFR-2011-title42-vol4-part455-subpartB).	Network Development	Attachment 6: Detailed Specifications Approach - Selection, Credentialing, Retention, Maintenance	Att 6 - Pages 401-415
ND018	1	The Vendor should describe how they will establish site visit criteria and evaluation as part of its credentialing process for Primary Care Providers (PCPs), Obstetrics and Gynecologists (OB/GYNs), Durable Medical Equipment (DME) providers, behavioral health providers, other high risk providers, and other highly utilized specialists.	Network Development	Attachment 6: Detailed Specifications Approach - Site Visits	Att 6 - Pages 416-417
ND019	1	The Vendor should describe its process for reimbursement of services that occur during mid-transfer of a treatment, when a recoupment is not available through the original provider (for example, orthodontia).	Network Development	Attachment 6: Detailed Specifications Approach - Reimbursement of Services during Mid-transfer of Treatment	Att 6 - Pages 417-418
ND020	1	The Vendor should describe how they will establish notification processes related to provider network terminations including, but not limited to, the following:	Network Development	Attachment 6: Detailed Specifications Approach - Notifications	Att 6 - Pages 418-419
ND021	2	Notification to the Department and the enrollment broker with advanced written notice of any Primary Care Provider (PCP) network deletions within fourteen calendar days	Network Development	Attachment 6: Detailed Specifications Approach - Notifications	Att 6 - Pages 419-420
ND022	2	Written notification to members, at least thirty calendar days prior to the termination, to allow the opportunity to select a new Primary Care Provider (PCP) before being assigned one	Network Development	Attachment 6: Detailed Specifications Approach - Notifications	Att 6 - Pages 420-421
ND023	2	Immediate notification of a hospital termination to the Department	Network Development	Attachment 6: Detailed Specifications Approach - Notifications	Att 6 - Pages 421
PS001	1	The Vendor should provide a description of its Provider Services operating model.	Provider Services	Attachment 6: Detailed Specifications Approach - Provider Services Operating Model	Att 6 - Pages 422-431

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Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
PS002	1	The Vendor should describe how its Provider Services Department will provide initial provider orientation, annual training, and support to its provider network.	Provider Services	Attachment 6: Detailed Specifications Approach - Provider Initial Orientation, Training and Support	Att 6 - Pages 431-449
PS003	1	The Vendor should describe its process for specialists serving as Primary Care Providers (PCPs), and related monitoring activities.	Provider Services	Attachment 6: Detailed Specifications Approach - Specialists Serving as PCPs	Att 6 - Pages 449-450
PS004	1	The Vendor should describe how its Provider Services Department will provide training to its provider network regarding culturally competent care.	Provider Services	Attachment 6: Detailed Specifications Approach - Cultural Competency Training	Att 6 - Pages 450-453
PS005	1	The Vendor should describe its annual review process of its provider manual, including thirty business days prior notice of any material changes to impacted providers.	Provider Services	Attachment 6: Detailed Specifications Approach - Provider Initial Orientation, Training and Support	Att 6 - Pages 442-449
PS006	1	The Vendor should describe how members are held harmless and protected from balance billing for covered services.	Provider Services	Attachment 6: Detailed Specifications Approach - Holding Members Harmless and Protected from Balanced Billing	Att 6 - Pages 453-454
PS007	1	The Vendor should describe how they will develop comprehensive Value-Based Payment (VBP) strategies that link provider payment levels to quality of care outcomes.	Provider Services	Attachment 6: Detailed Specifications Approach - Value-Based Payment	Att 6 - Pages 454-461
PS008	1	The Vendor should describe its process to conduct annual provider satisfaction surveys to evaluate the overall satisfaction of its network providers, including the evaluation of results of satisfaction surveys on an annual basis, and how the Vendor will utilize data to inform quality improvement activities to enhance network satisfaction and availability of services to members.	Provider Services	Attachment 6: Detailed Specifications Approach - Provider Satisfaction	Att 6 - Pages 461-470
CE001	1	The Vendor should describe its claims processing guidelines and systems requirements that ensure timely payment of all clean electronic and paper claims for covered services from both in-network and out-of-network providers, within thirty calendar days of receipt for Mountain Health Trust (MHT) members.	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Claims Processing Guidelines and Systems Requirements	Att 6 - Pages 543-553

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CE002	1	The Vendor should describe its claims processing guidelines for contractually obligated services to ensure that claims are paid at no less than 100% of the prevailing rate for Mountain Health Trust (MHT) Medicaid or West Virginia Children's Health Insurance Program (WVCHIP) Fee-for-Service (FFS) rate(s), as applicable.	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Processing Contractually Obligated Services at Prevailing Rates	Att 6 - Page 554
CE003	1	The Vendor should describe its claims processing guidelines that ensure the denial of claims payment for preventable provider and/or hospital acquired conditions as defined under Section 2702(a) of the Affordable Care Act (ACA) (https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf).	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Processing Preventable Provider Conditions and/or Hospital Acquired Conditions Claims	Att 6 - Pages 555-556
CE004	1	The Vendor should describe how they will implement rate changes adopted by the Department within thirty calendar days of notification of the rate change.	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Rate Change Implementation Process	Att 6 - Pages 556-558
CE005	1	The Vendor should describe how its claims processing systems and guidelines uphold payment policies that comport with the National Correct Coding Initiatives (NCCI) edits and/or other claims payment guidance defined by the Centers for Medicare & Medicaid Services (CMS) (https://www.cms.gov/medicare/coding/nationalcorrectcodinited/index.html).	Claims and Encounters	Attachment 6: Detailed Specifications Approach - NCCI and Related Claims Processing Systems and Guidelines	Att 6 - Pages 558-561
CE006	1	The Vendor should describe its claims processing guidelines and systems requirements that waive member co-payment or cost-sharing obligations for all applicable populations and covered services.	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Guidelines for Waiving Member Copayment or Cost-Sharing	Att 6 - Pages 561-563
CE007	1	The Vendor should describe its process to evaluate the data quality of its claims/encounters submissions to the Department including, but not limited to, the formatting and all data elements required to complete compliant 837 electronic transactions for medical and dental claims.	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Process to evaluate data quality of Claims/Encounter Data	Att 6 - Pages 563-570

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CE008	1	The Vendor should describe its encounter certification process that requires its Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other designee to certify the accuracy and completeness of its claims/encounter data information submitted to the Department.	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Encounter Certification and Reporting Process	Att 6 - Pages 570-571
CE009	1	The Vendor should describe its process that ensure complete and accurate encounter data is submitted to the Department on a monthly basis and no later than thirty calendar days after the end of the period in which the service was paid.	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Achieving Accurate and Timely Submission of Complete Encounter Data	Att 6 - Pages 571-573
CE010	1	The Vendor should describe its process and how they will implement a data accuracy and completeness monitoring program for its encounters that includes delegation oversight of subcontractors, as applicable.	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Encounter Accuracy and Completeness Monitoring Program	Att 6 - Pages 573-577
CE011	1	The Vendor should provide its annual encounter data accuracy and completeness plan with its bid.	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Annual Encounter Data Accuracy and Completeness Plan	Att 6 - Pages 577-580
CE012	1	The Vendor should describe its process to submit reports to the Department that summarize the encounter activity including, but not limited to, the following:	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Encounter Activity Reporting process	Att 6 - Pages 580-584
CE013	2	A detailed summary of the file submission that includes total claims and dollars by service category	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Encounter Activity Reporting process	Att 6 - Pages 581-582
CE014	2	A detailed change log that includes specifications for any change in the claims processing system that has an impact on the representation of the data in monthly encounter files	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Encounter Activity Reporting process	Att 6 - Pages 580, 582-584
CE015	1	The Vendor should describe its process to reconcile encounter data submitted to the Department with the financial data that it reports on a quarterly basis, including a narrative explaining any difference of five percent (5%) or higher.	Claims and Encounters	Attachment 6: Detailed Specifications Approach - Encounter Data Reconciliation Process	Att 6 - Pages 584-585

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
QU001	1	The Vendor should describe its Quality Assessment and Performance Improvement (QAPI) Program.	Quality	Attachment 6: Detailed Specifications Approach - Aetna's Quality Assessment and Performance Improvement Program	Att 6 - Pages 471-477
QU002	1	The Vendor should describe how they will coordinate Quality Assessment and Performance Improvement (QAPI) activities with other performance monitoring activities.	Quality	Attachment 6: Detailed Specifications Approach - Aetna's Quality Assessment and Performance Improvement Program	Att 6 - Pages 471-472, 477-478
QU003	1	The Vendor should describe how they will utilize data to identify barriers to care for individuals with special health care needs, and develop policies and procedures for methodologies for collecting and analyzing quality measures for different populations.	Quality	Attachment 6: Detailed Specifications Approach - Meeting the Needs of Individuals with Special Health Care Need and All Populations	Att 6 - Pages 530-542
QU004	1	The Vendor should describe how they will establish procedures for formal and ongoing communication and collaboration among the Quality Assessment and Performance Improvement (QAPI) policymaking body and other functional areas of the Vendor (for example, health services management and enrollee services).	Quality	Attachment 6: Detailed Specifications Approach - Aetna's Quality Assessment and Performance Improvement Program	Att 6 - Pages 471-472, 479-486
QU005	1	The Vendor should describe its approach to having staff and providers receive initial and ongoing training on health equity and Social Determinants of Health (SDOH).	Quality	Attachment 6: Detailed Specifications Approach - Health Equity and Social Determinants of Health Training	Att 6 - Pages 526-530
QU006	1	The Vendor should describe its policies and procedures regarding utilization of reports and data from subcontractors to ensure appropriate oversight and member access, satisfaction, and continuity of care.	Quality	Attachment 6: Detailed Specifications Approach - Ensuring Appropriate Oversight of Subcontractors	Att 6 - Pages 507-514
QU007	1	The Vendor should describe how they will administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.	Quality	Attachment 6: Detailed Specifications Approach - Member Satisfaction	Att 6 - Pages 514-518

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Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
QU008	1	The Vendor should describe its process to administer and utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results to identify and investigate areas of member dissatisfaction, outline action steps to follow up on survey findings, and disseminate findings with providers.	Quality	Attachment 6: Detailed Specifications Approach - Member Satisfaction	Att 6 - Pages 514-516, 518-526
QU009	1	The Vendor should describe how they will gather, report, and utilize audited Healthcare Effectiveness Data and Information Set (HEDIS) measures.	Quality	Attachment 6: Detailed Specifications Approach - Data Gathering and Oversight	Att 6 - Pages 494-498
QU010	1	The Vendor should describe how they will gather and use results for all identified core adult and child quality measures relevant to covered services to identify opportunities to improve member health outcomes, following the technical specifications provided by the Centers for Medicare & Medicaid Services (CMS) (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html), (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html).	Quality	Attachment 6: Detailed Specifications Approach - Data Gathering and Oversight	Att 6 - Pages 498-500
QU011	1	The Vendor should describe how they will develop standards of performance when providing healthcare and related services to members to meet all goals for performance improvement on specific measures, as established by the Department.	Quality	Attachment 6: Detailed Specifications Approach - Quality Strategies and Approach	Att 6 - Pages 487-488
QU012	1	The Vendor should describe its approach to developing performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Projects must measure performance using objective quality indicators, implement system interventions to achieve quality improvements, evaluate the effectiveness of the interventions, and plan and initiate activities for increasing or sustaining improvements.	Quality	Attachment 6: Detailed Specifications Approach - Quality Strategies and Approach	Att 6 - Pages 487, 488-492

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
QU013	1	The Vendor should describe how they will establish and utilize one or more quality indicators that are objective, clearly and unambiguously defined, and based on current knowledge or health services research, to assess its performance.	Quality	Attachment 6: Detailed Specifications Approach - Quality Strategies and Approach	Att 6 - Pages 487, 492-494
QU014	1	The Vendor should describe how they will use data to identify barriers to care for individuals with special health care needs.	Quality	Per Addendum No. 5, This question has been deleted. However, the topic is discussed in Attachment 6: Detailed Specifications Approach - Meeting the Needs of Individuals with Special Health Care Need and All Populations	Per Addendum No. 5, This question has been deleted. However, the topic is discussed in Att 6 - Pages 530-542
QU015	1	The Vendor should describe its policies and procedures to correct and remediate significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	Quality	Attachment 6: Detailed Specifications Approach - Data Gathering and Oversight	Att 6 - Pages 500-507
PI001	1	The Vendor should describe its administrative and management arrangements or procedures that are designed to detect, prevent, investigate, and report potential fraud, waste, and abuse (FWA).	Program Integrity	Attachment 6: Detailed Specifications Approach - Administrative and Management Arrangements and Procedures to Detect, Prevent, Investigate, and Report Potential FWA	Att 6 - Pages 594-599
PI002	1	The Vendor should describe its Special Investigations Unit (SIU) policies and procedures for identifying and investigating potentially or suspected fraudulent behavior, and its criteria for referring such behavior to the Department.	Program Integrity	Attachment 6: Detailed Specifications Approach - Special Investigations Unit Policies and Procedures	Att 6 - Pages 599-602
PI003	1	The Vendor should describe its process to work with the Department, the Medicaid Fraud Control Unit (MFCU), the Centers for Medicare & Medicaid Services (CMS), and the Department of Health and Human Services (DHHS), to administer effective fraud, waste, and abuse (FWA) detection and prevention practices.	Program Integrity	Attachment 6: Detailed Specifications Approach - Collaborate with Government Agencies to Administer Effective FWA Detection and Prevention Practices	Att 6 - Pages 602-607

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
PI004	1	The Vendor should describe how they will maximize resources for fraud, waste and abuse (FWA) issues.	Program Integrity	Attachment 6: Detailed Specifications Approach - Maximizing Aetna FWA Resources	Att 6 - Pages 607-609
PI005	1	The Vendor should describe its process for responding to all program integrity and Medicaid Fraud Control Unit (MFCU) requests within the timeframes established by the Department.	Program Integrity	Attachment 6: Detailed Specifications Approach - Responding to all Program Integrity and MFCU Requests	Att 6 - Pages 609-611
PI006	1	The Vendor should provide its compliance plan with clear goals, timelines, assignments, and measurements as outlined by the Department.	Program Integrity	Attachment 6: Detailed Specifications Approach - Detailed Summary of Program Integrity Plan	Att 6 - Pages 587-594
PI007	1	The Vendor should describe its training and education of the compliance officer and the organization's employees, including senior management, on State and federal standards and contract requirements.	Program Integrity	Attachment 6: Detailed Specifications Approach - FWA Training on State and Federal Standards and Contract Requirements	Att 6 - Pages 611-616
PI008	1	The Vendor should describe its disciplinary guidelines and procedures for enforcement of compliance standards.	Program Integrity	Attachment 6: Detailed Specifications Approach - Disciplinary Guidelines and Procedures for Enforcement of Compliance Standards	Att 6 - Pages 616-618
PI009	1	The Vendor should describe its procedures for routine internal monitoring, auditing, and remediation of compliance risks and identified issues.	Program Integrity	Attachment 6: Detailed Specifications Approach - Routine Internal Monitoring, Auditing, and Remediation of Compliance Risks	Att 6 - Pages 618-622
PI010	1	The Vendor should describe its oversight and monitoring process for any delegated functions and services, as provided by a subcontractor, in accordance with guidelines defined under the contract.	Program Integrity	Attachment 6: Detailed Specifications Approach - Subcontractor Oversight and Monitoring Processes	Att 6 - Pages 622-624
PI011	1	The Vendor should describe its process for monitoring provider fraud for underutilization of services and member/provider fraud for overutilization of services.	Program Integrity	Attachment 6: Detailed Specifications Approach - Monitoring Provider Fraud Related to Under-utilization and Member Fraud for Over-utilization of Services	Att 6 - Pages 624-628

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
PI012	1	The Vendor should describe its policies and procedures for denying, suspending, nonrenewal, or terminating affiliation with a contracting healthcare professional, including an appeals process, and for reporting serious quality deficiencies to appropriate authorities.	Program Integrity	Attachment 6: Detailed Specifications Approach - Denying, Suspending, Nonrenewal, or Terminating Providers	Att 6 - Pages 628-631
PI013	1	The Vendor should describe its policies regarding identification and recoupment of provider overpayments, and processes to coordinate with the Department.	Program Integrity	Attachment 6: Detailed Specifications Approach - Overpayment Processes and Determinations	Att 6 - Pages 632-635
IM001	1	The Vendor should describe its written policies and procedures for safeguarding and maintaining the confidentiality of data, including differences for adult and children populations.	Information Management Systems	Attachment 6: Detailed Specifications Approach - Aetna's Data Security Approach	Att 6 - Pages 637-638
IM002	1	The Vendor should provide its plan for how it will maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance, and maintain this compliance, throughout the life of the contract at no additional cost to the Department.	Information Management Systems	Attachment 6: Detailed Specifications Approach - Aetna's Data Security Approach	Att 6 - Pages 638-641
IM003	1	The Vendor should describe its policies to ensure that its staff, contracted providers, and all subcontractors that provide cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation maintain the confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI).	Information Management Systems	Attachment 6: Detailed Specifications Approach - Aetna's Data Security Approach	Att 6 - Pages 641-646
IM004	1	The Vendor should describe how its health information system collects, integrates, analyzes, and reports data necessary to implement and maintain its Quality Assessment and Performance Improvement (QAPI) Program.	Information Management Systems	Attachment 6: Detailed Specifications Approach - Using Information to Implement and Maintain our Quality Program	Att 6 - Pages 646-654
IM005	1	The Vendor should describe the flexibility of its health information system and processes utilized to develop requirements, configure, and test system changes as per new or modified contract requirements.	Information Management Systems	Attachment 6: Detailed Specifications Approach - Health information system and processes utilized	Att 6 - Pages 654-661
IM006	1	The Vendor should provide its business continuity and disaster recovery plan for the technology and infrastructure components of business operations with its bid.	Information Management Systems	Attachment 6: Detailed Specifications Approach - Business Continuity and Disaster Recovery	Att 6 - Pages 661-685

ATTACHMENT 7: TERMS AND CONDITIONS RESPONSE TEMPLATE

1. Instructions

The Vendor should review ***Attachment 7: Terms and Conditions Response Template***, signing each provided signature block using blue ink in order to note the Vendor's acknowledgement and intent of compliance. The Vendor should identify any exceptions to the Terms and Conditions. If exceptions are not noted in ***Attachment 7: Terms and Conditions Response Template*** of the RFP but raised during contract negotiations, the State reserves the right to cancel the negotiation if, at its sole discretion, it deems that to be in the best interests of the State.

2. RFP Terms and Conditions

RFP Terms and Conditions consist of provisions throughout this RFP. Moreover, these provisions encapsulate instructions, State and federal procedures, and the State's expectations of the Vendor when submitting a proposal. The Vendor should understand and strictly adhere to the RFP Terms and Conditions. Failure to follow any instructions within this RFP may, at the State's sole discretion, result in the disqualification of the Vendor's proposal.

Please provide an authorized signature stipulating the Vendor's acknowledgement, understanding, and acceptance of these RFP Terms and Conditions.

Printed Name / Signature of Authorized Personnel

FEB 19, 2020
Date

3. State Customary Terms and Conditions

The selected Vendor will sign a contract with the State to provide the goods and services described in the Vendor's response. The following documents shall be included in any contract(s) resulting from this RFP:

- ***Section 3: General Terms and Conditions (attached PDF file Section_2_Instructions_To_Vendors_Submitting_Bids_and_Section_3_General_Terms_and_Conditions)***
- ***Attachment 1: Provisions Required For Federally Funded Procurements***
- ***Appendix 3: Service Provider Agreement (SPA)***
- ***Business Associate Agreement***

Please provide a signature stipulating the Vendor's acknowledgement and complete review of these documents.

DAVID J. McNICHOLS, RPh FEB 10, 2020

Printed Name / Signature of Authorized Personnel Date

If the Vendor is not taking exceptions to any of the State Customary Terms and Conditions, then the Vendor needs to provide a binding signature stipulating its acceptance of these documents.

DAVID J. McNICHOLS, RPh FEB 10, 2020

Printed Name / Signature of Authorized Personnel Date

4. Mandatory Requirements and Terms

The following items are Mandatory Terms and Documents. Please be advised, the Vendor **should** provide its affirmative acceptance of these items in order to move forward with consideration under this RFP.

- Attachment 5: Mandatory Requirements (attached Microsoft Excel file, ***Attachment 5 – Mandatory Requirements***).
- Attachment 3, Section 2: Mandatory Qualifications.
- In no event shall the State agree to terms that (a) require indemnification by the State of the Contractor; (b) waive the State's right to a jury trial; (c) establish applicable law anywhere other than the State of West Virginia, or applicable jurisdiction's court of law; (d) designate a governing law other than the laws of the State of West Virginia; (e) constitute an implied or deemed waiver of the immunities, defenses, rights, or actions arising out of the State's sovereign status or under the Eleventh Amendment to the United States Constitution; (f) limit the time within which an action may be brought; (g) require arbitration; (h) require the ability to defend lawsuit without the approval of the Attorney General's Office; or (i) pay attorney fees.
- Business Associate's Agreement.

Vendors that are not able to enter into a contract under these conditions should not submit a bid.

Please provide an authorized signature stipulating the Vendor's acknowledgement, understanding, and acceptance of the Mandatory Requirements and Terms stipulated in this section.

RPh FEB 10, 2020

Printed Name / Signature of Authorized Personnel Date

5. Exceptions

If a Vendor has any identified exceptions to the State's Terms and Conditions, it must complete the West Virginia Addendum to Vendor's Standard Contractual Forms (WV-96), found at this link: (http://www.state.wv.us/admin/purchase/vrc/wv96.pdf).

Any exceptions should include an explanation for the Vendor's inability to comply with such term or condition and, if applicable, alternative language the Vendor would find acceptable. Rejection of the State's Terms and Conditions, in part or in whole, or without any explanation, may be cause for the State's rejection of a Vendor's Proposal. If an exception concerning the Terms and Conditions is not noted in this response template, but raised during contract negotiations, the State reserves the right to cancel the negotiation, at its sole discretion, if it deems that to be in the best interest of the State.

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

(Required by *W. Va. Code* § 6D-1-2)

Name of Contracting Business Entity: Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia **Address:** 500 Virginia Street East, Suite 400 Charleston, WV 25301

Name of Authorized Agent: David McNichols **Address:** 3600 Mansell Road, 4th Floor, Alpharetta, GA 30022

Contract Number: CRFP 0511 BMS2000000002 **Contract Description:** Mountain Health Trust (MHT) Managed Care

Governmental agency awarding contract: Department of Administration / Purchasing Division

☐ **Check here if this is a Supplemental Disclosure**

List the Names of Interested Parties to the contract which are known or reasonably anticipated by the contracting business entity for each category below *(attach additional pages if necessary)*:

1. **Subcontractors or other entities performing work or service under the Contract**

   ☐ Check here if none, otherwise list entity/individual names below.

   Please see the list of subcontractors on the following page.

2. **Any person or entity who owns 25% or more of contracting entity (not applicable to publicly traded entities)**

   ☐ Check here if none, otherwise list entity/individual names below.

   Aetna Health Holdings, LLC has a 25% or more direct ownership interest in Aetna Better Health of West Virginia. Aetna Inc., CVS Pharmacy, Inc., and CVS Health Corporation each have a 25% or more indirect ownership interest in Aetna Better Health of West Virginia. CVS Health Corporation, Aetna Better Health of West Virginia's ultimate parent, is a publicly traded entity.

3. **Any person or entity that facilitated, or negotiated the terms of, the applicable contract (excluding legal services related to the negotiation or drafting of the applicable contract)**

   ☑ Check here if none, otherwise list entity/individual names below.

Signature: _____ Date Signed: 01/27/2020

Notary Verification

State of Connecticut, County of Hartford:

I, David J. McNichols, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledge that the Disclosure herein is being made under oath and under the penalty of perjury.

Taken, sworn to and subscribed before me this 27th day of January, 2020.

Cynthia Montano
Notary Public's Signature

To be completed by State Agency:

Date Received by State Agency: _____

Date submitted to Ethics Commission: _____

Governmental agency submitting Disclosure: _____

Revised June 8, 2018

1. Subcontractors or other entities performing work or service under the contract:

- Active Health Management, Inc.
- Aetna Health Management, LLC
- Aetna Medicaid Administrators LLC
- Center for the Study of Services
- Cotiviti a/k/a iHT Services, LLC a/k/a iHealth Technologies a/k/a Connolly LLC
- CQ Fluency
- Emdeon a/k/a Envoy LLC and Chamberlin Edmonds & Associates d/b/a Change Healthcare
- Equian, LLC
- eviCore healthcare MSA, LLC d/b/a eviCore healthcare (f/k/a MedSolutions, Inc.)
- First Choice Services
- Health Management Systems Inc.
- Inovolan, Inc.
- MCMC, LLC
- NantHealth, Inc.
- Prest & Associates, LLC
- SKYGEN USA, LLC
- Symphony Performance Health, Inc. d/b/a SPH Analytics
- Vision Service Plan, Inc.
- Welltok, Inc.

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

CONSTRUCTION CONTRACTS: Under W. Va. Code § 5-22-1(i), the contracting public entity shall not award a construction contract to any bidder that is known to be in default on any monetary obligation owed to the state or a political subdivision of the state, including, but not limited to, obligations related to payroll taxes, property taxes, sales and use taxes, fire service fees, or other fines or fees.

ALL CONTRACTS: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that: (1) for construction contracts, the vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia

Authorized Signature: _____ Date: 01/27/2020

State of Connecticut

County of Hartford, to-wit:

Taken, subscribed, and sworn to before me this 27th day of January, 2020.

My Commission expires March 31, 2021.

AFFIX SEAL HERE

NOTARY PUBLIC Cynthia Montano

CYNTHIA MONTANO
Notary Public, State of Connecticut
My Commission Expires March 31, 2021

Appendix A

Aetna Inc. and CVS Health Corporation Additional Office Locations

Aetna Office Addresses

2300 Yonge Street, Toronto, ON M4P1E4
5F Standard Charter Tower, Shanghai, 31 200120
757 Meng Zi Rd, Huangpu, Shanghai, 200023
No. 50 Liangmaqiao Rd, Beijing, 11 100125
50 Cannon St, London, GT LON EC4V2BE
25 Templar Avenue, Farnborough, HANTS GU146FE
No. 25 Westlands Road, Quarry Bay, 00000
213-B Okhla Indust Ph 3, New Delhi, 110020
Sagar Tech Plaza, Mumbai, 000000
Sentral Senayan 11 W-16, Jakarta, 12 10270
Alexandra House-The Sweepstakes, Dublin, 00000
373 Gangnam-daero seocho-gu, Seoul, 11 100843
330 Lambton Quay, Wellington, 01 6011
112 Robinson Rd 9-01, Singapore, 068902
1277 Mike Crawford Ave, Centurion, 00000
Media One Tower, Plot A008-001, Dubai, 00000
North Twr - Emirates Finl Tower, Dubai, 03 00000
2525 C Street, Anchorage, AK 99503
One Sealaska Plaza, Juneau, AK 99801
4350 E. Cotton Center Blvd., Phoenix, AZ 85040
1830 N. 95th Avenue, Phoenix, AZ 85037
18444 North 25th Ave, Phoenix, AZ 85023
4500 E. Cotton Center Blvd, Phoenix, AZ 85040
4025 E. Cotton Center Blvd, Phoenix, AZ 85040
9801 S. 51st Street, Phoenix, AZ 85044
4750 S 44TH Place, Phoenix, AZ 85040
3535 E. Valencia Rd., Tucson, AZ 85706
4141 N Scottsdale Road, Scottsdale, AZ 85251
8969 West McCartney Road, Casa Grande, AZ 85194
1333/1385 East Shaw Avenue, Fresno, CA 93710
10370/10390 Commerce Ctr Dr, Rancho Cucamonga, CA 91730
515 South Flower Street, Los Angeles, CA 90071
750 Riverpoint Drive, W. Sacramento, CA 95605
2677 North Main Street, Santa Ana, CA 92705
2850 Shadelands Dr, Walnut Creek, CA 94598
10260 Meanley Drive, San Diego, CA 92131
One Sansome Street, San Francisco, CA 94104
21215 Burbank Blvd, Woodland Hills, CA 91367
1500 Wynkoop Street, Denver, CO 80202
4582 S Ulster St, Denver, CO 80237
20 Glover Avenue, Norwalk, CT 06850
29 South Main Street, West Hartford, CT 06107
100 Signature Way, E Granby, CT 06026
151 Farmington Ave Rogers Bldg, Hartford, CT 06156
151 Farmington Ave, C&T Annex, Hartford, CT 06156
151 Farmington Avenue, Atrium Bldg, Hartford, CT 06156
570 Pigeon Hill Rd, Data Center, Windsor, CT 06095
930 Middle St, Data Center, Middletown, CT 06457
252 Chapman Rd., Newark, DE 19702
750 Prides Crossing Ste 200, Newark, DE 19713
789 SW Federal Hwy, Stuart, FL 34994
1340 Concord Terrace, Sunrise, FL 33323
8200 NW 41st St, Doral, FL 33166
9000 Southside Blvd Bld 100, Jacksonville, FL 32256
503 Sunport Lane, Orlando, FL 32809
502 Sunport Lane, Orlando, FL 32809
4630 Woodland Corporate Blvd, Tampa, FL 33614
3611 Queen Palm Drive, Tampa, FL 33619
1820 E Park Ave, Tallahassee, FL 32301
1301 N. Congress Ave., Boynton Beach, FL 33426
1600 SW 80th Terrace, Plantation, FL 33324
1100 Abernathy Rd, NE Bldg 500, Atlanta, GA 30328
1100 Circle 75 Parkway Ste 1400, Atlanta, GA 30339
2000 Riveredge Parkway, Atlanta, GA 30328
3600 Mansell Road, Alpharetta, GA 30022
333 W Wacker Dr, Chicago, IL 60606
550 W Washington Blvd, Chicago, IL 60661
10 S Riverside Plaza, Chicago, IL 60606
2110 Fox Drive, Champaign, IL 61820
4507 N. Sterling Ave., Peoria, IL 61615
One Overlook Point, Lincolnshire, IL 60069
3200 Highland Ave., Downers Grove, IL 60515
3800 Golf Road, Rolling Meadows, IL 60008
111 SE 3rd St, Evansville, IN 47708
3500 Coliseum Blvd East, Ft Wayne, IN 46805
8910 Purdue Rd, Indianapolis, IN 46268
4320 NW 114th St, Urbandale, IA 50322
8535 East 21st St N, Wichita, KS 67206
9401 Indian Creek Parkway, Overland Park, KS 66210
9900 Corporate Campus Dr., Louisville, KY 40223
10000 Perkins Rowe, Bldg G, Ste 500, Baton Rouge, LA 70810
920 Pierremont Rd, Shreveport, LA 71106
3838 N. Causeway Blvd., Metairie, LA 70002
2400 Veterans Memorial Blvd, Kenner, LA 70062
175 Running Hill Road, South Portland, ME 04106
6720-B Rockledge Drive, Bethesda, MD 20817
13511 Label Lane, Hagerstown, MD 21740
15400 Calhoun Drive, Rockville, MD 20855
509 Progress Dr., Linthicum, MD 21090
53 State St, Boston, MA 02109
77 S. Bedford Street, Burlington, MA 01803
93 Worcester St, Wellesley, MA 02481
2725 Airview Blvd, Kalamazoo, MI 49002
1333 Gratiot Ave, Detroit, MI 48207
3200 Eagle Park Dr NE, Grand Rapids, MI 49525
1044 Eastbury Drive, Lansing, MI 48917
2612 Ashman Street, Midland, MI 48640
2356/2370 Science Parkway, Okemos, MI 48864
28588 Northwestern Highway, Southfield, MI 48034
1405 Xenium Lane North, Plymouth, MN 55441
10991 NW Airworld Drive, Kansas City, MO 64153
4520 South National Ave, Springfield, MO 65810
550 Maryville Centre Drive, St Louis, MO 63141
10802 Farnam Dr, Omaha, NE 68154
15950 W Dodge Road, Omaha, NE 68118
639 Isbell Rd, Reno, NV 89509

1140 Town Center Drive, Las Vegas, NV 89144
475 E Capovilla Ave, Las Vegas, NV 89119
303 Fellowship Road, Mt. Laurel, NJ 08054
100 Willowbrook Road, Freehold, NJ 07728
9 Entin Road, Parsippany, NJ 07054
3 Independence Way, Princeton, NJ 08540
15 Columbia Circle, Albany, NY 12203
1333 Broadway, New York, NY 10018
100 Park Avenue, New York, NY 10017
55 West 125th Street, New York, NY 10027
350 Madison Ave, New York, NY 10017
36 West 25th St, New York, NY 10010
101 Park Ave, New York, NY 10178
100 Park Ave - 27th Fl, New York, NY 10017
88 Froehlich Farms Blvd, Woodbury, NY 11797
300 Corporate Parkway, Amherst, NY 14226
2815 Coliseum Centre Drive, Charlotte, NC 28217
4050 Piedmont Parkway, High Point, NC 27265
2700 X-Ray Drive, Gastonia, NC 28054
2801 Slater Road, Morrisville, NC 27560
1800 East Interstate Avenue, Bismarck, ND 58503
2841 Woodburn Ave, Cincinnati, OH 45206
178 E. State St, Columbus, OH 43215
7400 West Campus Road, New Albany, OH 43054
3015 Glendale Ave, Toledo, OH 43617
3805 Edwards Rd, Cincinnati, OH 45209
4059 Kinross Lakes Parkway, Richfield, OH 44286
3201 Enterprise Parkway, Beachwood, OH 44122
3030 N.W. Expwy Ste 625, Oklahoma City, OK 73112
6120 South Yale Avenue, Tulsa, OK 74136
222 S.W. Columbia Street, Portland, OR 97201
120 E Kensinger Drive, Cranberry, PA 16066
2222 Ewing Road, Moon Township, PA 15108
1425 Union Meeting Road, Blue Bell, PA 19422
3721 TecPort Drive, Harrisburg, PA 17111
1550 Pond Road, Allentown, PA 18104
2000 Market Street, Philadelphia, PA 19103
730 Holiday Dr, Pittsburgh, PA 15220
11 Stanwix Street, Pittsburgh, PA 15222
221 Dawson Rd, Columbia, SC 29224
5350 Poplar Ave, Memphis, TN 38119
1801 West End Avenue, Nashville, TN 37203
800 Crescent Centre Drive, Franklin, TN 37067
2777 Stemmons Freeway, Dallas, TX 75207
135 Oyster Creek, Lake Jackson, TX 77566
Three Sugar Creek Center, Sugar Land, TX 77478
14955 Heathrow Forest Pkwy, Houston, TX 77032
4400 NW Loop 410, San Antonio, TX 78229
3900 Rogers Road, San Antonio, TX 78251
2800 N Dallas Parkway, Plano, TX 75093
9606 N. Mopac Expressway, Austin, TX 78759
4300 Centreway Place, Arlington, TX 76018
257 E 200 S, Salt Lake City, UT 84111
10150 South Centennial Parkway, Sandy, UT 84070
250 W Center St, Provo, UT 84601
630 Peter Jefferson Pkwy, Charlottesville, VA 22911
100 Linden Square Drive, Bristol, VA 24202
6387 Center Dr, Norfolk, VA 23502
9881 Mayland Drive, Richmond, VA 23233
310 1st St SW, Roanoke, VA 24011
1380-1382 Town Square Boulevard NW, Roanoke, VA 24012
2010 Corporate Ridge Road, McLean, VA 22102
14155 Newbrook Drive, Chantilly, VA 20151
600 University St, Seattle, WA 98101
20 F Street, NW, Washington, DC 20001
500 Virginia St East, Charleston, WV 25301

CVS Corporate Office Addresses

444 North 44th Street, Phoenix, AZ, 85008
9501 E Shea Boulevard, Scottsdale, AZ, 85260
555 17th St, Ste 1500, Denver, CO, 80202
1275 Pennsylvania Avenue, NW, Suite 700, Washington, DC, 20004
2211 Sanders Road, Northbrook, IL, 60062
4900 Koger Boulevard #100, Greensboro, NC, 27407
200 Campus Drive, Suite 310, Florham Park, NJ, 07932
29100 Aurora Road, Solon, OH, 44139
100 Scenic View Drive, Cumberland, RI, 02864
200 Highland Corporate Drive, Cumberland, RI, 02864
100 Highland Corporate Drive, Cumberland, RI, 02864
4 Blackstone Valley Place, Lincoln, RI, 02865
11 Blackstone Valley Place, Lincoln, RI, 02865
25 Blackstone Valley Place, Lincoln, RI, 02865
695 George Washington Highway, Lincoln, RI, 02865
935 Douglas Pike, Smithfield, RI, 02917
One CVS Drive, Woonsocket, RI, 02895
1026 Park East Drive, Woonsocket, RI, 02895
475 Park East Drive, Woonsocket, RI, 02895
750 W John Carpenter Freeway, Suite 1200, Irving, TX, 75039
909 E Collins Boulevard, Richardson, TX, 75081

Please note that CVS Health Corporation and its subsidiaries (including CVS Pharmacy, Inc.) operate over 10,000 retail pharmacy, LTC pharmacy, mail service pharmacy, specialty pharmacy, PDP, infusion provider and clinical provider locations. Addresses for such additional business locations can be provided upon request.

Appendix B

NCQA Certificate

NCQA
Measuring quality
Improving health care

National Committee for Quality Assurance

has awarded

Coventry Health Care of West Virginia, Inc. d/b/a Aetna Better Health of West Virginia

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

Medicaid HMO

an accreditation status of

Commendable

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

David Chin, MD
CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

09/20/2019
DATE GRANTED

09/20/2022
EXPIRATION DATE

2.wv20

Appendix C

Sanctions for Vendor and Medicaid Health Plans Managed by Aetna..... App C-3

Sanctions for Medicare and Other Federal Health Program Business..... App C-45

Sanctions for IlliniCare Health Plan, Inc. ..... App C-51

CVS 3rd Quarter 2019 10-Q Legal Matters..... App C-59

CVS 2nd Quarter 2019 10-Q Legal Matters ..... App C-69

CVS 1st Quarter 2019 10-Q Legal Matters ..... App C-79

CVS 2018 10-K Legal Matters ..... App C-89

Aetna 3rd Quarter 2018 10-Q Legal Matters ..... App C-99

Aetna 2nd Quarter 2018 10-Q Legal Matters..... App C-107

Aetna 1st Quarter 2018 10-Q Legal Matters..... App C-115

Aetna 2017 10-K Legal Matters..... App C-123

CVS 2017 10-K Legal Matters ..... App C-129

Sanctions for Vendor and Medicaid Health Plans Managed by Aetna

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	4/26/2019	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$20,155	Paid
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	4/26/2019	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$1,690	Paid
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	4/26/2019	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$11,710	Paid
AZ	Mercy Care/DDD	2/1/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$2,540	Paid
AZ	Mercy Care fka Mercy Maricopa Integrated Care	1/22/2019	Other	Notice of Non-Compliance	Implemented process efficiencies to ensure no future occurances	N/A	N/A
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	1/22/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$42,395	Paid
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	12/14/2018	Other	Notice of Non-Compliance	Performed root cause analysis and implemented required fixes	N/A	N/A

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	12/11/2018	Other	Sanction	Performed root cause analysis and implemented required fixes	$100,000	Paid
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	11/8/2018	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$136,000	Paid
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	10/29/2018	Other	Sanction	Performed root cause analysis and implemented required fixes	$50,000	Paid
AZ	Mercy Care fka Mercy Care Plan/ DDD	10/23/2018	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$1,235	Paid
AZ	Mercy Care fka Mercy Care Plan/ DDD	10/4/2018	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$230	Paid
AZ	Mercy Care fka Mercy Care Plan/ DDD	9/27/2018	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$1,230	Paid
AZ	Mercy Care fka Mercy Maricopa Integrated Care	9/27/2018	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$16,085	Paid
AZ	Mercy Care fka Mercy Care Plan/ DDD	8/8/2018	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$16,550	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
AZ	Mercy Care fka Mercy Care Plan/ DDD	8/6/2018	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$13,550	Paid
AZ	Mercy Care fka Mercy Maricopa Integrated Care	6/21/2018	Other	Corrective Action Plan	Re-educated staff on contractual requirements	N/A	OPEN
AZ	Mercy Care fka Mercy Care Plan/ DDD	5/2/2018	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$7,690	Paid
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	4/24/2018	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$9,035	Paid
AZ	Mercy Care fka Mercy Maricopa Integrated Care	4/24/2018	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$7,725	Paid
AZ	Mercy Care fka Mercy Care Plan/ DDD	3/19/2018	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$835	Paid
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	3/8/2018	Reporting – encounter data	Sanction	Implemented process efficiencies to ensure no future occurances	$4,005	Paid
AZ	Mercy Care fka Mercy Maricopa Integrated Care	3/8/2018	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$6,765	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	3/1/2018	Other	Audit/Review - Data Validation Audit	Re-educated staff on contractual requirements	N/A	Additional information requested by state. Mercy Care submitted timely on 4.24.2019. Awaiting results.
AZ	Mercy Care fka Mercy Maricopa Integrated Care	3/1/2018	Other	Sanction	Refocus of priorities to contractual requirements	$1,207	Paid
AZ	Mercy Care fka Mercy Maricopa Integrated Care	11/16/2017	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$840	Paid
AZ	Mercy Care fka Mercy Maricopa Integrated Care	11/7/2017	Other	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	OPEN
AZ	Mercy Care fka Mercy Maricopa Integrated Care	10/6/2017	Other	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	OPEN - Continued monthly reporting to regulator

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
AZ	Mercy Care fka Mercy Maricopa Integrated Care	8/23/2017	Other	CAP	Refocus of priorities to contractual requirements	N/A	Open, escalated to a CAP from NONC - Mercy Care challenged. Partially accepted. 2 CAPS submitted. Awaiting regulator response for final closure.
AZ	Mercy Care fka Mercy Care Plan/ Acute and ALTCS Plan	7/25/2017	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$3,275	Paid
AZ	Mercy Care fka Mercy Maricopa Integrated Care	7/25/2017	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$6,730	Paid
AZ	Mercy Care fka Mercy Maricopa Integrated Care	7/17/2017	Other	AHCCCS Operational Review	Refocus of priorities to contractual requirements	No	Overall Compliance Score of 97%
CA	Aetna Better Health of California/Medi-Cal Geographic Managed Care	3/6/2019	Other	DHCS/HSAG HEDIS Audit	Re-educated staff on contractual requirements	N/A	Open
CA	Aetna Better Health of California/Medi-Cal Geographic Managed Care	11/5/2018	Other	DMHC Orientation Examination (Audit)	Re-educated staff on contractual requirements	N/A	Closed, no findings.

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
CA	Aetna Better Health of California/Medi-Cal Geographic Managed Care	7/9/2018	Other	DHCS CAP	Re-educated staff on contractual requirements	N/A	Closed
CA	Aetna Better Health of California/Medi-Cal Geographic Managed Care	6/5/2018	Other	DHCS CAP	Refocus of priorities to contractual requirements	N/A	Open
CA	Aetna Better Health of California/Medi-Cal Geographic Managed Care	4/16/2018	Other	DHCS Medical Audit	Performed root cause analysis and implemented required fixes	N/A	Closed, no findings.
FL	Coventry Health Care of Florida, Inc.	4/17/2019	Claims processing timeliness	Fine	Refocus of priorities to contractual requirements	$10,000	Paid
FL	Coventry Health Care of Florida, Inc.	3/15/2019	Reporting – other data	Fine	Performed root cause analysis and implemented required fixes	$500	Paid
FL	Coventry Health Care of Florida, Inc.	2/25/2019	Other	Fine	Refocus of priorities to contractual requirements	$4,000	Paid
FL	Coventry Health Care of Florida, Inc.	2/18/2019	Reporting – encounter data	Fine	Refocus of priorities to contractual requirements	$2,000	Paid
FL	Coventry Health Care of Florida, Inc.	2/1/2019	Other	Audit-FHK EQRO	Pending	N/A	Preliminary findings-score of 99%. Awaiting final resuls

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
FL	Coventry Health Care of Florida, Inc.	11/7/2018	Reporting – other data	Fine	Refocus of priorities to contractual requirements	$1,500	Paid
FL	Coventry Health Care of Florida, Inc.	11/7/2018	Other	Fine	Refocus of priorities to contractual requirements	$22,800	Paid
FL	Coventry Health Care of Florida, Inc.	11/7/2018	Other	Fine	Performed root cause analysis and implemented required fixes	$409,200	Paid
FL	Coventry Health Care of Florida, Inc.	10/1/2018	Other	Fine	Refocus of priorities to contractual requirements	$10,000	Paid
FL	Coventry Health Care of Florida, Inc.	6/22/2018	Other	Fine	Refocus of priorities to contractual requirements	$9,000	Paid
FL	Coventry Health Care of Florida, Inc.	6/18/2018	Access standards	Fine	Refocus of priorities to contractual requirements	$2,500	Paid
FL	Coventry Health Care of Florida, Inc.	6/8/2018	Other	Fine	Refocus of priorities to contractual requirements	$31,500	Paid
FL	Coventry Health Care of Florida, Inc.	4/30/2018	Claims processing accuracy	Fine	Refocus of priorities to contractual requirements	$120,000	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
FL	Coventry Health Care of Florida, Inc.	4/20/2018	Reporting – other data	Fine	Refocus of priorities to contractual requirements	$8,000	Paid
FL	Coventry Health Care of Florida, Inc.	4/20/2018	Claims processing accuracy	Fine	Refocus of priorities to contractual requirements	$6,500	Paid
FL	Coventry Health Care of Florida, Inc.	4/13/2018	Reporting – other data	Fine	Implemented process efficiencies to ensure no future occurances	$3,250	Paid
FL	Coventry Health Care of Florida, Inc.	4/10/2018	Reporting – other data	Fine	Refocus of priorities to contractual requirements	$1,000	Paid
FL	Coventry Health Care of Florida, Inc.	3/30/2018	Other	Fine	Refocus of priorities to contractual requirements	$250	Paid
FL	Coventry Health Care of Florida, Inc.	3/16/2018	Reporting – other data	Fine	Performed root cause analysis and implemented required fixes	$1,250	Paid
FL	Coventry Health Care of Florida, Inc.	3/15/2018	Other	Fine	Refocus of priorities to contractual requirements	$1,000	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
FL	Coventry Health Care of Florida, Inc.	2/12/2018	Reporting – other data	Fine	Refocus of priorities to contractual requirements	$1,000	Paid
FL	Coventry Health Care of Florida, Inc.	2/9/2018	Quality of care	Fine	Refocus of priorities to contractual requirements	$2,500	Paid
FL	Coventry Health Care of Florida, Inc.	2/2/2018	Reporting – other data	Fine	Refocus of priorities to contractual requirements	$48,750	Paid
FL	Coventry Health Care of Florida, Inc.	1/26/2018	Reporting – other data	Fine	Refocus of priorities to contractual requirements	$1,000	Paid
FL	Coventry Health Care of Florida, Inc.	1/19/2018	Claims processing accuracy	Fine	Refocus of priorities to contractual requirements	$90,000	Paid
FL	Coventry Health Care of Florida, Inc.	1/19/2018	Claims processing accuracy	Fine	Re-educated staff on contractual requirements	$10,000	Paid
FL	Coventry Health Care of Florida, Inc.	1/19/2018	Reporting – other data	Fine	Refocus of priorities to contractual requirements	$1,000	Paid
FL	Coventry Health Care of Florida, Inc.	1/12/2018	Reporting – other data	Fine	Refocus of priorities to contractual requirements	$4,000	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
FL	Coventry Health Care of Florida, Inc.	1/12/2018	Reporting – other data	Fine	Refocus of priorities to contractual requirements	$500	Paid
FL	Coventry Health Care of Florida, Inc.	12/8/2017	Other	Fine	Refocus of priorities to contractual requirements	$257,800	Paid
FL	Coventry Health Care of Florida, Inc.	12/8/2017	Other	Fine	Performed root cause analysis and implemented required fixes	$117,050	Paid
FL	Coventry Health Care of Florida, Inc.	12/8/2017	Other	Fine	Refocus of priorities to contractual requirements	$20,700	Paid
FL	Coventry Health Care of Florida, Inc.	12/1/2017	Other	Fine	Re-educated staff on contractual requirements	$1,000	Paid
FL	Coventry Health Care of Florida, Inc.	11/14/2017	Other	Fine	Refocus of priorities to contractual requirements	$250	Paid
FL	Coventry Health Care of Florida, Inc.	10/20/2017	Reporting – other data	Fine	Re-educated staff on contractual requirements	$20,000	Paid
FL	Coventry Health Care of Florida, Inc.	8/11/2017	Reporting – encounter data	Fine	Refocus of priorities to contractual requirements	$1,000	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
FL	Coventry Health Care of Florida, Inc.	7/14/2017	Claims processing accuracy	Fine	Refocus of priorities to contractual requirements	$30,000	Paid
IL	Medicare Medicaid Alignment Initiative	10/18/2018	Access standards	Notice of Non-Compliance	Performed root cause analysis and implemented required fixes	$0	Closed
IL	Family Health Plan, Integrated Care Plan, Medicare Medicaid Alignment Initiative	5/4/2018	Other	HSAG Corrective Action Plan	Refocus of priorities to contractual requirements	$0	Closed
IL	Family Health Plan	10/17/2017	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$50,000	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/19/2019	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$39,990	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/17/2019	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$345,567	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/19/2019	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$53,127.00	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/2/2019	Other	CAP	Refocus of priorities to contractual requirements	N/A	CAP accepted
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/15/2019	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$308,272.01	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/6/2019	Other	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	N/A
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	2/15/2019	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$309,936.37	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/18/2019	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$317,383.21	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/15/2019	Reporting – encounter data	Notice of Non-Compliance	Re-educated staff on contractual requirements	N/A	N/A

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/21/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Re-educated staff on contractual requirements	$359,577.44	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/16/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$295,822.23	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/30/2018	Other	CAP	Refocus of priorities to contractual requirements	N/A	N/A
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/26/2018	Reporting – encounter data	CAP	Re-educated staff on contractual requirements	N/A	N/A
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/20/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Re-educated staff on contractual requirements	$574,889.58	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/16/2018	Other	Audit-EQRO	Pending	N/A	Results currently under review by DMS

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/14/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Re-educated staff on contractual requirements	$395,405.18	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/13/2018	Other	CAP	Re-educated staff on contractual requirements	N/A	Open
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/18/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$326,900.75	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/25/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$15,840.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/21/2018	Other	Due to legacy issues	Refocus of priorities to contractual requirements	$246,253.72	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/15/2018	Reporting – encounter data		Refocus of priorities to contractual requirements	$369,905.25	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/18/2018	Reporting – other data		Refocus of priorities to contractual requirements	$419,408.50	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/20/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Performed root cause analysis and implemented required fixes	$307,342.14	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/27/2018	Other	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$5,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/16/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$333,699.07	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	2/16/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Performed root cause analysis and implemented required fixes	$462,165.10	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/24/2018	Other	CAP	Performed root cause analysis and implemented required fixes	N/A	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/18/2018	Reporting – other data		Refocus of priorities to contractual requirements	$419,408.50	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/20/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Performed root cause analysis and implemented required fixes	$307,342.14	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/27/2018	Other	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$5,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/16/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$333,699.07	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	2/16/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Performed root cause analysis and implemented required fixes	$462,165.10	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/24/2018	Other	CAP	Performed root cause analysis and implemented required fixes	N/A	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/18/2018	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Performed root cause analysis and implemented required fixes	$372,948.33	Paid
KY	Kentucky Insurance Company/ Medicaid Managed Care Contract	12/20/2017	Other	CAP	Refocus of priorities to contractual requirements	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/19/2017	Other	CAP	Refocus of priorities to contractual requirements	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/18/2017	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$408,703.42	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/17/2017	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$370,928.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/20/2017	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$373,469.17	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/19/2017	Other	Audit/Review	Refocus of priorities to contractual requirements	N/A	Closed-CAP submitted and accepted
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/28/2017	Claims processing timeliness	Notice of Non-Compliance	Re-educated staff on contractual requirements	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/19/2017	Claims processing accuracy	Sanction/Fine/Liquidated Damages	Re-educated staff on contractual requirements	$15,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/19/2017	Claims processing accuracy	Sanction/Fine/Liquidated Damages	Re-educated staff on contractual requirements	$25,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/19/2017	Claims processing accuracy	Sanction/Fine/Liquidated Damages	Re-educated staff on contractual requirements	$25,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/18/2017	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Performed root cause analysis and implemented required fixes	$361,928.00	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/14/2017	Other	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/13/2017	Other	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/18/2017	Claims processing accuracy	CAP	Refocus of priorities to contractual requirements	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/18/2017	Claims processing accuracy	CAP	Refocus of priorities to contractual requirements	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/17/2017	Reporting – other data	CAP	Performed root cause analysis and implemented required fixes	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/16/2017	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$360,217.11	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/14/2017	Claims processing timeliness	CAP	Refocus of priorities to contractual requirements	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/10/2017	Other	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$1,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/9/2017	Claims processing timeliness	CAP	Re-educated staff on contractual requirements	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/26/2017	Other	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$10,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/26/2017	Claims processing accuracy	CAP	Implemented process efficiencies to ensure no future occurances	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/24/2017	Other	Notice of Non-Compliance	Re-educated staff on contractual requirements	N/A	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/24/2017	Other	CAP	Refocus of priorities to contractual requirements	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/21/2017	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$359,095.78	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/17/2017	Claims processing accuracy	CAP	Refocus of priorities to contractual requirements	N/A	Closed
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	4/16/2019	Other	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	Closed
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	4/2/2019	Claims processing timeliness	Sanction	Refocus of priorities to contractual requirements	$105,000	Paid
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	2/25/2019	Other	Sanction	Refocus of priorities to contractual requirements	$15,000	Paid
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	2/15/2019	Other	Sanction	Refocus of priorities to contractual requirements	$50,000	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	12/4/2018	Other	Sanction	Refocus of priorities to contractual requirements	$500,000	Paid
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	10/19/2018	Other	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	Closed
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	6/25/2018	Other	Notice of Non-Compliance	Performed root cause analysis and implemented required fixes	$50,000	Paid
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	11/21/2017	Other	Notice of Non-Compliance	Performed root cause analysis and implemented required fixes	N/A	Closed
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	10/25/2017	Reporting – other data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	$182,000	Paid
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	10/1/2017	Other	EQRO- Claims/Encounters	Refocus of priorities to contractual requirements	N/A	Closed- four recommendations for financial reconciliation of encounters for subcontracted vendor Dentaquest.
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	10/1/2017	Other	CMS CPI Audit	Refocus of priorities to contractual requirements	N/A	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
LA	Aetna Better Health, Inc. (LA)/ Healthy Louisiana	7/21/2017	Reporting – other data	Sanction	Performed root cause analysis and implemented required fixes	$44,000	Paid
MD	Aetna Better Healht of Michigan	2/20/2019	Other	Audit-UM and Credentialing	No action required as there were no findings.	N/A	Closed, no findings.
MI	Aetna Better Health of Michigan Inc.	04/23/2018 & 07/20/2018	Reporting – other data	CAP	Refocus of priorities to contractual requirements	N/A	Closed
MI	Aetna Better Health of Michigan Inc.	2/25/2019	Reporting – other data	CAP	Refocus of priorities to contractual requirements	N/A	Open
MI	Aetna Better Health of Michigan Inc.	1/23/2019	Other	None	Refocus of priorities to contractual requirements	N/A	Closed
MI	Aetna Better Health of Michigan Inc.	11/28/2018	Reporting – other data	CAP	Refocus of priorities to contractual requirements	N/A	Closed
MI	Aetna Better Health of Michigan Inc.	10/2/2018	Reporting – other data	CAP	Performed root cause analysis and implemented required fixes	N/A	Closed
MI	Aetna Better Health of Michigan Inc.	9/5/2018	Other	CAP - no State submission required	Refocus of priorities to contractual requirements	N/A	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
MI	Aetna Better Health of Michigan Inc.	7/24/2018	Other	None	Refocus of priorities to contractual requirements	N/A	Closed
MI	Aetna Better Health of Michigan Inc.	7/10/2018	Reporting – other data	CAP	Refocus of priorities to contractual requirements	N/A	Closed
MI	Aetna Better Health of Michigan Inc.	5/21/2018	Reporting – other data	CAP	Refocus of priorities to contractual requirements	N/A	Closed
MI	Aetna Better Health of Michigan Inc.	3/12/2018	Reporting – other data	CAP	Refocus of priorities to contractual requirements	N/A	Closed
MI	Aetna Better Health of Michigan Inc.	9/21/2017	Reporting – other data	CAP	Performed root cause analysis and implemented required fixes	N/A	Closed
MI	Aetna Better Health of Michigan Inc.	8/18/2017	Other	Sanction	Performed root cause analysis and implemented required fixes	$1,000	Paid
MI	Aetna Better Health of Michigan Inc.	7/26/2017	Other	None	Refocus of priorities to contractual requirements	N/A	Closed
NJ	Aetna Better Health Inc. (NJ)/ Family Care	6/20/2019	Other	Sanction	Re-educated staff on contractual requirements	$5,372	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
NJ	Aetna Better Health Inc. (NJ)/ Family Care	2/27/2019	Claims processing accuracy	CAP	Refocus of priorities to contractual requirements	N/A	CAP submitted and accepted
NJ	Aetna Better Health Inc. (NJ)/ Family Care	12/31/2018	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$8,374	Paid
NJ	Aetna Better Health Inc. (NJ)/ Family Care	9/21/2018	Other	Sanction/Fine/Liquidated Damages	Performed root cause analysis and implemented required fixes	$369	Paid
NJ	Aetna Better Health Inc. (NJ)/ Family Care	9/18/2018	Other	CAP	Performed root cause analysis and implemented required fixes	N/A	CAP submitted
NJ	Aetna Better Health Inc. (NJ)/ Family Care	3/22/2018	Other	IPRO Audit	Performed root cause analysis and implemented required fixes	N/A	CAP submitted and accepted
NJ	Aetna Better Health Inc. (NJ)/ Family Care	3/1/2018	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$8,171	Paid
NJ	Aetna Better Health Inc. (NJ)/ Family Care	2/13/2018	Other	Notice of Deficiency - CAP (CAP)	Performed root cause analysis and implemented required fixes	N/A	CAP submitted and accepted.
NJ	Aetna Better Health Inc. (NJ)/ Family Care	2/1/2018	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$2,354	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
NJ	Aetna Better Health Inc. (NJ)/ Family Care	10/1/2017	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$404	Paid
NJ	Aetna Better Health Inc. (NJ)/ Family Care	9/29/2017	Other	MLTSS Audit	Re-educated staff on contractual requirements	N/A	Closed-CAP submitted and accepted
NJ	Aetna Better Health Inc. (NJ)/ Family Care	9/14/2017	Other	OIG Audit	Re-educated staff on contractual requirements	N/A	Closed-CAP submitted and accepted
NJ	Aetna Better Health Inc. (NJ)/ Family Care	8/1/2017	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$1,057	Paid
NJ	Aetna Better Health Inc. (NJ)/ Family Care	7/1/2017	Reporting – encounter data	Sanction	Re-educated staff on contractual requirements	$1,057	Paid
NY	Aetna Better Health Inc. (NY)/ MMP Product	9/28/2018	Other	Validation (PMV) audit which will look at the 2017 data for its MMP product. Final report	Re-educated staff on contractual requirements	$0	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
NY	Aetna Better Health Inc. (NY)/ Managed Long-Term Care	8/12/2018	Other	On 8/27/18 the plan was notified by the Department of Health (DOH) that it failed the completeness measure for dental during Q1 of 2018. The percent change of the accepted encounters went beyond the benchmark of >-10% which resulted in a penalty of $16,318.00. On 9/11/18 the plan submitted an appeal of the finding and is awaiting the outcome of the state review. On 3/4/19 the plan was notified that its appeal was accepted and no fine or other action will be taken. Issue closed.	Re-educated staff on contractual requirements	$0	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
NY	Aetna Better Health Inc. (NY)/ FIDA	4/1/2018	Other	On 4/19/18 the plan was notified by the Department of Health (DOH) that its FIDA product failed the encounter submission completeness measure for pharmacy during Q4 of 2017. The percent change of the accepted encounters went beyond the benchmark of >-10% which resulted in a penalty of $14,389.95. On 5/4/18 the plan submitted an appeal and on 5/23/18 the appeal was accepted. No fine or penalty.	Re-educated staff on contractual requirements	$0	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
NY	Aetna Better Health Inc. (NY)/ Managed Long-Term Care	11/1/2017	Other	The plan did not meet the encounter completeness measure for Q1 on completeness and the accuracy measure for Q2. This will result in a 1/2% reduction of the per member per month capitation payment to the due to the plan for the affected time frames. This reduction equals approximately $115,000. A corrective action plan has been put in place by the encounters team and the issue has been corrected.	Re-educated staff on contractual requirements	$115,000	Closed
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	10/4/2018 - 4/18/2019	Audit	2018/2019 Encounter Data Validation Audit	No action required as there were no findings.	N/A	Closed; no CAPs.
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	6/11/2018- 6/13/2018	Care Management chart audit	Ohio Department of Medicaid Care Management file review	No action required as there were no findings.	N/A	Final report issued 7/21/2018. no findings; Closed
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	12/10/2019- 12/12/2018	Care Management chart audit	Ohio Department of Medicaid Care Management file review	No action required as there were no findings.	N/A	Final report issued 1/14/2019 no findings
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	02/11/2019- 02/15/2019	Care Management chart audit	Ohio Department of Medicaid Care Management file review	No action required as there were no findings.	N/A	Open - Draft report issued 2/21/2019 no findings

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	3/15/2019	Other	Notice of Non-Compliance; CAP submitted on 4/22/2019	Pending	N/A	Open
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	2/25/2019	Program Integrity Audit	Audit Notice and MCE questionnaire issued 02/25/2019	Pending	N/A	Open
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	2/25/2019	Other	Notice of Non-Compliance	Pending	$372,010.08 ($248,006.72 potentially refundable)	Open
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	11/19/2018	Reporting - other data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	$59,078	$59,077.56 refunded 2/26/2019
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	10/15/2018	Other	Sanction	Refocus of priorities to contractual requirements	$5,000	Paid
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	2/26/2018	Other	Ohio Department of Medicaid Care Management file review	No action required as there were no findings.	NA	Reports issued 3/6/18 and 3/22/18, no findings
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	2/13/2018	Reporting – other data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	$0	NONC replaces the NONC dated 2/8/18 and rescinds the $1000 fine in the 2/8/18 NONC.
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	2/8/2018	Reporting – other data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	$1,000 "rescinded"	NONC rescinded and replaced by NONC dated 2/13/18

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	1/30/2018	Other	Sanction and CAP	Refocus of priorities to contractual requirements	$10,000	Sanction Paid: Updated CAPs submitted 2/13/18 open
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	12/11/2017	Other	Ohio Department of Medicaid Care Management file review	Refocus of priorities to contractual requirements	NA	Report issued 1/26/18 NONC issued 1/30/2018
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	11/17/2017	Reporting – other data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	Closed 11/17/2017
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	10/30/2017	Reporting – encounter data	Notice of Ohio Department of Medicaid validation of encounter data	Refocus of priorities to contractual requirements	N/A	In progress
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	10/16/2017	Quality of care	Audit notice for Ohio Department of Medicaid field review of incident investigations	No action required as there were no findings.	N/A	On site review occurred 1/16/2018. Results were issued 2/12/18 with no findings.
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	9/22/2017	Other	CAP	Refocus of priorities to contractual requirements	N/A	CAP Submitted and Open - Request to close CAP submitted on 3/28/18
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	9/13/2017	Care Management chart audit	Ohio Department of Medicaid Care Management file review	Re-educated staff on contractual requirements	N/A	Final narrative report issued 1/26/2018; NONC issued 1/30/2018

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
OH	Aetna Better Health Inc. (OH)/ MyCare Ohio (Duals)	8/3/2017	Network deficiency	Notice of Non-Compliance	Performed root cause analysis and implemented required fixes	$2,000	Paid
PA	Aetna Better Health	4/30/2019	Other	DHS Audit	Performed root cause analysis and implemented required fixes	N/A	Closed, no CAPS. 3 recommendations
PA	Aetna Better Health	1/1/2019	Other	Mercer Claims/Encounters Audit	Performed root cause analysis and implemented required fixes	N/A	Closed, no CAPS. Recoomendations only
PA	Aetna Better Health	1/19/2019	DHS/Mercer Review	Audit/Review	Refocus of priorities to contractual requirements	N/A	Awaiting final report from Mercer
PA	Aetna Better Health	9/1/2018	DHS	Audit/Review	Refocus of priorities to contractual requirements	N/A	Closed; no findings
PA	Aetna Better Health/Aetna Better Health Kids	4/18/2018	NCQA	CAP	Refocus of priorities to contractual requirements	N/A	One element (UM5D) fell below the 80% compliance rate for NCQA which required a CAP. CAP was approved and accepted by DOH and all items have been implemented.

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
PA	Aetna Better Health	3/1/2018	DHS	Audit/Review	Refocus of priorities to contractual requirements	N/A	Final report pending
PA	Aetna Better Health Kids	2/1/2018	DHS	Audit/Review	Refocus of priorities to contractual requirements	N/A	Closed; no findings
PA	Aetna Better Health Inc. (PA) (as successor in interest to HealthAmerica Pennsylvania, Inc.)/ HealthChoices	12/5/2017	Claims processing accuracy	Sanction	Refocus of priorities to contractual requirements	$4,000	Paid
PA	Aetna Better Health & Aetna Better Health Kids	12/1/2017	NCQA	Audit/Review	Refocus of priorities to contractual requirements	N/A	Accredited
PA	Aetna Better Health Inc. (PA) (as successor in interest to HealthAmerica Pennsylvania, Inc.)/ HealthChoices	11/6/2017	Claims processing accuracy	Sanction	Refocus of priorities to contractual requirements	$333	Paid
PA	Aetna Better Health, Kids	9/1/2017	Financial – non claims	Audit/Review	Re-educated staff on contractual requirements	N/A	Closed; no findings
PA	Aetna Better Health	8/20/2018	Access standards	CAP	Re-educated staff on contractual requirements	N/A	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
PA	Aetna Better Health	6/1/2018	DHS/KMPG	Audit Review	Refocus of priorities to contractual requirements	N/A	Closed; no findings
TX	Aetna Better Health of Texas	2/25/2019	Reporting – other data	Sanction	Refocus of priorities to contractual requirements	$9,875	Paid
TX	Aetna Better Health of Texas	2/25/2019	Provider Complaints	Fine	Refocus of priorities to contractual requirements	$0	Waived
TX	Aetna Better Health of Texas	6/28/2019	Other	TDI Triennial Audit	Refocus of priorities to contractual requirements	$170,000	Fine Paid; CAP submitted and accepted.
TX	Aetna Better Health of Texas	5/24/2018	Reporting – other data	Fine	Refocus of priorities to contractual requirements	$250	Paid
TX	Aetna Better Health of Texas	11/8/2017	Reporting – encounter data	Fine	Re-educated staff on contractual requirements	$8,000	Paid
TX	Aetna Better Health of Texas	11/8/2017	Other	Fine	Refocus of priorities to contractual requirements	$25	Paid
TX	Aetna Better Health of Texas	9/30/2017	Member Complaint	Fine	Refocus of priorities to contractual requirements	$0	Waived

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
TX	Aetna Better Health of Texas	9/30/2017	Member Hotline	Fine	Refocus of priorities to contractual requirements	$100	Paid
TX	Aetna Better Health of Texas	9/30/2017	Nurse Hotline	Fine	Refocus of priorities to contractual requirements	$650	Paid
TX	Aetna Better Health of Texas	9/30/2017	Member Appeals	Fine	Refocus of priorities to contractual requirements	$125	Paid
TX	Aetna Better Health of Texas	9/30/2017	Claims Lag Report	Fine	Re-educated staff on contractual requirements	$0	Waived
TX	Aetna Better Health of Texas	9/30/2017	Claims Summary Report	Fine	Refocus of priorities to contractual requirements	$1,250	Paid
TX	Aetna Better Health of Texas	9/30/2017	Claims Summary Report	Fine	Re-educated staff on contractual requirements	$2,500	Paid
TX	Aetna Better Health of Texas	9/30/2017	Claims Summary Report	Fine	Refocus of priorities to contractual requirements	$0	Waived
TX	Aetna Better Health of Texas	9/30/2017	Claims Summary Report	Fine	Refocus of priorities to contractual requirements	$1,750	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
TX	Aetna Better Health of Texas	9/30/2017	Claims Summary Report	Fine	Refocus of priorities to contractual requirements	$1,750	Paid
VA	Aetna Better Health of Virginia/Commonwealth Coordinated Care Plus	6/12/2019	Claims processing accuracy	CAP	Refocus of priorities to contractual requirements	$1,000	Paid
VA	Aetna Better Health of Virginia/Commonwealth Coordinated Care Plus	2/14/2019	Claims processing timeliness	Notice of Non-Compliance	Re-educated staff on contractual requirements	N/A	Open
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	2/1/2019	Reporting – other data	Notice of Non-Compliance	Re-educated staff on contractual requirements	N/A	Closed
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	2/1/2019	Reporting – other data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	Closed
VA	Aetna Better Health of Virginia/Commonwealth Coordinated Care Plus	12/21/2018	Claims processing timeliness	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	Open
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	11/2/2018	Reporting – other data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
VA	Aetna Better Health of Virginia/Commonwealth Coordinated Care Plus	7/6/2018	Claims processing timeliness	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	Closed
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	6/1/2018	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$5,000	paid
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	4/30/2018	Reporting – encounter data	CAP	Re-educated staff on contractual requirements	$5,000	Closed; CAP accepted; paid
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	3/5/2018	Reporting – other data	Sanction	Refocus of priorities to contractual requirements	$10,000	Paid
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	2/2/2018	Reporting – encounter data	CAP	Refocus of priorities to contractual requirements	$5,000	Closed; CAP accepted; paid
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	11/30/2017	Reporting – other data	Sanction	Re-educated staff on contractual requirements	$5,000	Paid
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	11/30/2017	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$5,000	Paid
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	10/31/2017	Claims processing timeliness	Sanction	Refocus of priorities to contractual requirements	$5,000	Paid

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	10/31/2017	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$5,000	Paid
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	9/29/2017	Reporting – other data	CAP	Refocus of priorities to contractual requirements	$5,000	Paid
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	9/29/2017	Reporting – encounter data	Sanction	Refocus of priorities to contractual requirements	$5,000	Paid
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	9/29/2017	Reporting – encounter data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	No	Closed
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	8/30/2017	Reporting – encounter data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	No	Closed
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	8/30/2017	Reporting – encounter data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	No	Closed
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	8/30/2017	Reporting – encounter data	Notice of Non-Compliance	Re-educated staff on contractual requirements	No	Closed
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	8/30/2017	Reporting – other data	Notice of Non-Compliance	Performed root cause analysis and implemented required fixes	No	Closed

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	8/30/2017	Reporting – other data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	No	Closed
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	8/14/2017	Other	CAP	Refocus of priorities to contractual requirements	No	Closed
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	8/14/2017	Other	CAP	Refocus of priorities to contractual requirements	No	Closed
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	7/31/2017	Reporting – encounter data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	No	Closed
VA	Aetna Better Health of Virginia/Medallion 3.0 and/or FAMIS	7/31/2017	Reporting – other data	Notice of Non-Compliance	Refocus of priorities to contractual requirements	No	Closed
WV	Coventry Health Care of West Virginia, Inc.	4/5/2019	Claims processing timeliness	CAP	Pending	N/A	CAP Submitted. Awaiting final disposition from the State.
WV	Coventry Health Care of West Virginia, Inc.	3/12/2019	Other	Corrective Action Plan	Performed root cause analysis and implemention of required fixes is underway	N/A	Open

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
WV	Coventry Health Care of West Virginia, Inc.	1/16/2019	Reporting – other data	Sanction	Refocus of priorities to contractual requirements	$1,500	Paid
WV	Coventry Health Care of West Virginia, Inc.	11/14/2018	Other	Notice of Non-Compliance	Refocus of priorities to contractual requirements	N/A	Closed
WV	Coventry Health Care of West Virginia, Inc.	6/19/2018	Other	EQRO Audit (One Finding with Program Integrity): Systems Performance Review of Enrollee Rights; MCO Standards minus Availability of Standards; Program Integrity Contract Requirements. Finding was language inefficient to meet contractual requirement to notify State Regulator or fraud referral to entity other than State Regulatory.	Required language was updated to meet contractual requirements	N/A	Closed

Sanctions for Medicare and Other Federal Health Program Business

Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
12/2019	Other	Failure to provide accurate communications	Notice of Non-Compliance	No	Closed
12/2019	Other	Failure to have a state license in states in which the organization offers MA plans.	Notice of Non-Compliance	No	Closed
12/2019	Other	Failure to provide accurate communications	Notice of Non-Compliance	No	Closed
11/2019	Other	Failure to adhere to marketing requirements. Specifically, marketing for the 2020 plan year prior to October 1,2019; failing to include the material ID on the material; and failing to include required disclaimers on the material.	Notice of Non-Compliance	No	Closed
10/2019	Other	Failure to send out Integrated Denial Notices (IDN) to members using the current model as issued by CMS and MDHHS with the correct appeals process and ombudsman information.	Notice of Non-Compliance	No	Closed
09/2019	Other	CY2018 CMS Financial Audit of Aetna	TBD	TBD	Audit in Process
09/2019	Other	CY2018 CMS Financial Audit of Innovation Health	TBD	TBD	Audit in Process
09/2019	Other	Audit of CY2020 Bid	TBD	TBD	Pending Issuance of Final Report
07/2019	Other	CY2018 CMS Performance Audit of Aetna	TBD	TBD	Pending Issuance of Final Report
05/2019	Other	Failure to meet the CMS standard for the disconnect percentage rate for the CMS Call Center metrics for Q1-2019	Notice of Non-Compliance	No	Closed
04/2019	Other	Failure to include correct information regarding eye exams, hearing aid, and transportation benefits in the CY 2019 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)/Member Handbook	Notice of Non-Compliance	No	Closed
04/2019	Other	Failure to accurately describe benefits and/or cost sharing information in Annual Notice of Change (ANOC) document(s) which prevents enrollees from making a fully informed health care choice.	Notice of Non-Compliance	No	Closed
04/2019	Other	Failure to meet administrative and management requirements - Low Star Ratings. CMS is requesting that your organization develop and implement a corrective action plan designed to ensure that it will achieve at least an "average" star rating. (1 Contract)	Ad-hoc Corrective Action Plan (CAP)	No	Closed
04/2019	Claims processing accuracy	Failure to meet the CMS' requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Notice of Non-Compliance	No	Closed
03/2019	Other	Failure to adhere to the September 12, 2018 HPMS memo regarding the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) accuracy assessment	Notice of Non-Compliance	No	Closed

Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
02/2019	Other	Audit of CY2019 Bid	No Corrective Action Plan requested. As part of CY2020 bid submission Aetna was required to include information on how we have remediated bid audit findings.	No	Closed
01/2019	Other	Failure to meet the CMS standard for average hold time for the CMS Call Center Metrics for Q4-2018	Notice of Non-Compliance	No	Closed
01/2019	Other	Inappropriate Marketing of the Open Enrollment Period	Notice of Non-Compliance	No	Closed
11/2018	Other	Failure to maintain accurate online Part C Provider Directory.	Warning Letter	No	Closed
10/2018	Other	Failure to meet the Interpreter Availability call center standard during the 2018 Accuracy and Accessibility Study for Part C and/or Part D prospective enrollee beneficiary customer service phone lines	Notice of Non-Compliance	No	Closed
08/2018	Other	CY2016 CMS Financial Audit	Ad-hoc Corrective Action Plans (CAPs)	No	Closed
07/2018	Other	CY2018 Monitoring of Marketed Comprehensive Formulary Errors	Notice of Non-Compliance	No	Closed
06/2018	Other	Failure to Ensure Sales Agents are Licensed	Notice of Non-Compliance	No	Closed
04/2018	Other	Failure to provide accurate information regarding premiums in a marketing piece.	Notice of Non-Compliance	No	Closed
04/2018	Reporting – other data	Failure to timely upload Actual Mail Dates for Contract Year 2018 Annual Notice of Change/Evidence of Coverage documents for Material ID(s): Y0001_2018_CB_S5768_186c126_ANOCEOC.	Notice of Non-Compliance	No	Closed
03/2018	Other	Failure to meet the CMS standard for average hold time during the first quarter (Q1) of 2018 for Part C and/or Part D current enrollee beneficiary customer service and/or pharmacy technical help desk phone lines	Notice of Non-Compliance	No	Closed
02/2018	Claims processing accuracy	Failure to properly implement a formulary transition program consistent with Part D requirements, as indicated by the results of CMS' enhanced transition monitoring program, referred to as the Transition Monitoring Program Analysis (TMPA) project	Ad-hoc Corrective Action Plan (CAP)	No	Closed
02/2018	Reporting – other data	Failure to submit the correct formulary files (EGWP) by the filing deadline	Notice of Non-Compliance	No	Closed
02/2018	Other	Failure to administer a formulary according to CMS requirements by making negative formulary changes to the EGWP base formulary without approval from CMS	Notice of Non-Compliance	No	Closed
02/2018	Other	Failure to Submit Complete and Accurate Bid Submission - Total Beneficiary Cost	Notice of Non-Compliance	No	Closed
02/2018	Other	Audit of CY2018 Bid	No Corrective Action Plan requested. As part of CY2020 bid submission Aetna was required to include information on how we have remediated bid audit findings.	No	Closed

Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
02/2018	Claims processing accuracy	Failure to properly implement the required Transition Policy	Warning Letter	No	Closed
02/2018	Claims processing accuracy	Failure to properly implement the required Transition Policy	Warning Letter with a Request for a Business Plan	No	Closed
01/2018	Reporting – other data	Failure to submit enrollment reconciliations	Notice of Non-Compliance	No	Closed

Sanctions for IlliniCare Health Plan, Inc.

State	Contract / Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
IL	Illinois Department of Healthcare and Family Services	4/27/2016	IlliniCare received a Notice of Non-Compliance from HFS for not completing the required percentage of new member care plans for both its ICP and FHP contracts. IlliniCare was required to become compliant by January 1, 2017 and provided bi-monthly updates. Illinicare continues to monitor care plan completion rates. IlliniCare submitted a letter to HFS with documentation of compliance and a formal request to withdraw the Notice of Non-Compliance.	Notice of Non-Compliance	IlliniCare conducts bi-weekly check-ins to monitor the status. IlliniCare submitted a closure request March 2017 due to achieving 85% completion for ICP and 73% completion for FHP.	N/A	

State	Contract / Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
IL	Illinois Department of Healthcare and Family Services	3/14/2018	IlliniCare received a notice of non-compliance from HFS (Bureau of Behavioral Health) on 3/14/18 stating that HFS has completed the review of IlliniCare's Illinois MCO Parity Analysis Template. HFS identified the following areas of non-compliance: (1) IlliniCare did not perform Quantitative Treatment Limitations (QTL) testing on the Inpatient, Outpatient or Emergency classification due to their adoption of State-driven limitations. Per Section 5.8.10 of the 2018 MCO Contract, IlliniCare must establish and maintain compliance with parity requirements. IlliniCare must complete an analysis of QTLs for all classifications and report their findings to HFS. Any parity compliance deficiencies must be identified and a corrective action plan submitted. If there are parity deficiencies that are a result of State-driven limitations, HFS will provide guidance to IlliniCare regarding correcting those deficiencies; (2) Additional information is required for Claims Rejection Rates for Inpatient, Outpatient and Emergency services; (3) Reported Prior Authorization standards are more stringent and restrictive for Inpatient Mental Health and Substance Use Disorder services, which is non-compliant with parity requirements; (4) Additional information is required for the Inpatient Concurrent Review; (5) Additional information is required for the Outpatient Prior Authorization; (6) Additional information is required to determine if administrative barriers exist related to Pharmacy Claims Rejection Rates. IlliniCare must submit a Plan of Correction	Notice of Non-Compliance	Implementation of all remediated items was completed by the secondary deadline (7/1/18) provided to HFS in the initial response and analysis.	N/A	

State	Contract / Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
IL	Illinois Department of Healthcare and Family Services - Medicaid	4/17/2018	Health Plan received three (3) Requests for Corrective Action Plans today related to Illinois' MCO Provider Complaint portal (the "Portal"). The requests related to non-timely responses to three (3) Provider Portal tickets.	CAP	CAPs are due on April 21st and 30th, but will be submitted by Friday, April 20. We will inform HFS that all Provider Portal complaints will be internally answered and submitted to HFS at least 24 hours before the provided due date. In addition, the Senior VP of Compliance and the Senior VP of Operations will monitor Portal complaints and aging of complaints on the Tuesday and Thursday of every week. The Provider Portal response team has also been trained on HFS's new policy which came out on 4/17/18. Finally, IlliniCare plans to do a root cause analysis of all complaints in the last 12 months from both the state portal and through provider relations. Remediation will be implemented based on the findings of the analysis	N/A	
IL	Illinois Department of Healthcare and Family Services - Medicaid	5/14/2018	IlliniCare received a CAP due to the MCO Provider Complaint portal. Health Plan received a ticket on November 6, 2017 and did not respond timely.	CAP		N/A	

State	Contract / Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
	Illinois Department of Healthcare and Family Services	12/21/2018	CAP related to deficiencies in quality and performance metrics required by a consent decree.	CAP	Four Corrective Action Plans were submitted to IDoA on December 27, 2018. There was a follow up meeting with IDoA on Friday January 4th, 2019. IDoA presented IlliniCare staff with a formal letter and a Transition Achievement Plan with 10 areas of correction that IDoA set the deadline for January 18, 2019. Debra Brophy set the internal Deadline for a draft Transition Achievement Plan to be completed by COB on 1/9/2019. Long Term Care and Support Services Department has already worked with IDoA to set up future trainings, increased monitoring of staff accuracy and time frame completion, and adjusting targets to improve quality of assessments over quantity. Extra focus has been given to areas that were identified in the Transition Achievement Plan.	N/A	

State	Contract / Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
	Illinois Department of Healthcare and Family Services	1/23/2019	CAP related to a failure for two service plans to meet 85% goal for Colbert Decree members.	CAP	To improve overall assessment and service plan reviews quality scores peer-to-peer support via clinical rotation was implemented on 7/1/2019. Employees with scores below 70% were placed on corrective action including supervision and weekly monitoring.	N/A	
IL	Illinois Department of Healthcare and Family Services - Medicaid	6/26/2019	IlliniCare received a sanction in the amount of $50,000 from the Illinois Department of Healthcare and Family Services (HFS) for failure to meet Encounter Utilization Monitoring (EUM) thresholds. Pursuant to the HealthChoice Medicaid contract section 7.16.6 there is 96% threshold for EUM. IlliniCare Health's overall score of 93.92% for Encounter Summary Report EUM 2019 Evaluation Period 2 was below the 96% threshold.	Sanction	In order to reach the required acceptance percentage, we will need to make data corrections/enhancements to rejected encounters as well as install claims edits to prevent paying claims for which we cannot create clean encounters.	$50,000	Paid
IL	Illinois Department of Healthcare and Family Services - Medicaid	10/21/2019	IlliniCare received a sanction in the amount of $50,000 from the Illinois Department of Healthcare and Family Services (HFS) for failure to meet Encounter Utilization Monitoring (EUM) thresholds. Pursuant to the HealthChoice Medicaid contract section 7.16.6 there is 96% threshold for EUM. IlliniCare Health's overall score of 95.15% for Encounter Summary Report EUM 2019 Evaluation Period 3 was below the 96% threshold.	Sanction		$50,000	Paid

CVS 3rd Quarter 2019 10-Q Legal Matters

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)
☑ QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the quarterly period ended September 30, 2019
or

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to_____

Commission File Number: 001-01011

CVSHealth
CVS HEALTH CORPORATION
(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(401) 765-1500**

Former name, former address and former fiscal year, if changed since last report: **N/A**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.01 per share	CVS	New York Stock Exchange

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. **☑ Yes ☐ No**

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). **☑ Yes ☐ No**

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

12. Commitments and Contingencies

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of September 30, 2019, the Company guaranteed approximately 79 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the unaudited condensed consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies' usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. In June 2019, the Company and the Texas Attorney General commenced a civil jury trial in the *qui tam* action. Prior to the conclusion of that trial, the parties reached a settlement in principle on the remaining issues.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. In June 2019, the U.S. Court of Appeals for the Ninth Circuit reversed the District Court's grant of summary judgment and reversed the District Court's narrowing of the requested class. The *Corcoran* case is now proceeding to a trial on a class basis. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Circuit Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi, originally in the Chancery Court, but later transferred to the Circuit Court. The complaint alleged that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In June 2019, the Company's motion for judgment on the pleadings was granted in part and denied in part. Also in June 2019, the State of Mississippi's motion to dismiss the Company's counterclaim for declaratory relief was granted. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

Bewley, et al. v. *CVS Health Corporation*, et al. and *Prescott*, et al. v. *CVS Health Corporation*, et al. (both previously pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases alleged that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims were made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases were transferred to the U.S. District Court for the District of New Jersey on defendants' motions. In April 2019, the named plaintiffs in both the *Bewley* and *Prescott* cases voluntarily dismissed all of their claims without prejudice, ending both cases.

Klein, et al. v. *Prime Therapeutics*, et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation*. The Company is defending itself against these claims.

The Company has received subpoenas, CIDs, and other requests for documents and information from, and is being investigated by, Attorneys General of several states regarding its PBM practices, including pricing and rebates. In addition, the Company received an inquiry from the U.S. Senate Committee on Finance regarding insulin pricing. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. In addition, the Company has been named as a defendant in similar cases brought by certain state Attorneys General. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General and insurance and other regulators of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). In some instances, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served the Company with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Omnicare pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Omnicare pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the trial arbitrator awarded the claimant hospitals approximately $150 million. Aetna appealed the trial arbitrator's decision. On March 28, 2019, the appellate arbitrator reduced the award to approximately $86 million. The proceeding has ended. During the nine months ended September 30, 2019, the Company recorded the reduction in the required reserve amount for this proceeding as a measurement period adjustment to its Aetna Acquisition accounting and recorded a reduction to goodwill.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

The United States Centers for Medicare & Medicaid Services ("CMS") regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified

in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange-related or other audits by CMS, the OIG, the United States Department of Health and Human Services or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the United States Department of Justice (the "DOJ") in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. On September 4, 2019, the United States District Court for the District of Columbia (the "D.C. District Court") entered a final order that concluded the court approval process for the consent decree under the Antitrust Procedures and Penalties Act. The final order was issued without conditions. No further action is required by the D.C District Court, the DOJ or any other entity with regard to CVS Health's acquisition of Aetna.

Shareholder Matters

Between February and August 2019, six class action complaints were filed by putative plaintiffs against the Company and certain current and former officers and directors: *Anarkat v. CVS Health Corp., et al.,* Case No. 1:19-cv-00437 (U.S. District Court for the District of Rhode Island); *Labourers' Pension Fund of Central and Eastern Canada v. CVS Health Corp., et al.,* Case No. 651700/2019 (New York Supreme Court); *City of Warren Police and Fire Retirement Sys.v. CVS Health Corp., et. al.*, Case No. PC-2019-5658 (Rhode Island Superior Court); *Cambria Co. Employees Retirement Sys. v. CVS Health Corp., et al.*, Case No. 653223/2019 (New York Supreme Court); *Freundlich v. CVS Health Corp., et al.*, Case No. PC-2019-6685 (Rhode Island Superior Court); and *Waterford Twp. Police & Fire Retirement Sys. v. CVS Health Corp., et al.,* Case No. 19-cv-00434 (U.S. District Court for the District of Rhode Island). The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit, which allegedly injured investors who acquired CVS Health securities between February 9, 2016 and February 20, 2019. The *Freundlich* case also alleges that defendants misrepresented anticipated synergies of the Aetna Acquisition. The Company is defending itself against these claims.

Other Legal and Regulatory Proceedings

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, arising, for the most part, in the ordinary course of its businesses. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and

employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

13. Segment Reporting

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Effective for the first quarter of 2019, adjusted operating income is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. Segment financial information for the three and nine months ended September 30, 2018 has been retrospectively adjusted to conform with the current period presentation. See the reconciliation of consolidated operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

CVS 2nd Quarter 2019 10-Q Legal Matters

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)
☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2019
or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to_____

Commission File Number: 001-01011

CVSHealth

CVS HEALTH CORP ORATION
(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation)	(IRS Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)
Registrant's telephone number, including area code:	**(401) 765-1500**
Former name or former address, if changed since last report:	**N/A**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.01 per share	CVS	New York Stock Exchange

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☑	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ **Yes** ☑ **No**

There were 1,300,496,722 shares of the registrant's voting common stock with a par value of $0.01 per share outstanding at July 30, 2019 .

11. Commitments and Contingencies

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of June 30, 2019 , the Company guaranteed approximately 79 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the unaudited condensed consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies' usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. In June 2019, the Company and the Texas Attorney General commenced a civil jury trial in the *qui tam* action. Prior to the conclusion of that trial, the parties reached a settlement in principle on the remaining issues.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. In June 2019, the Ninth Circuit reversed the District Court's granting of summary judgment and reversed the District Court's narrowing of the requested class. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Circuit Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi, originally in the Chancery Court, but later transferred to the Circuit Court. The complaint alleged that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In June 2019, the Company's motion for judgment on the pleadings was granted in part and denied in part. Also in June 2019, the State of Mississippi's motion to dismiss the Company's counterclaim for declaratory relief was granted. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

Bewley, et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases have been transferred to the U.S. District Court for the District of New Jersey on defendants' motions. In April 2019, the named plaintiffs in both the *Bewley* and *Prescott* cases voluntarily dismissed all of their claims without prejudice, ending both cases.

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The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). In some instances, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served the Company with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Omnicare pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Omnicare pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

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In October 2015, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the trial arbitrator awarded the claimant hospitals approximately $150 million . Aetna appealed the trial arbitrator's decision. On March 28, 2019, the appellate arbitrator reduced the award to approximately $86 million . The proceeding has ended. During the six months ended June 30, 2019 , the Company recorded the reduction in the required reserve amount for this proceeding as a measurement period adjustment to its Aetna Acquisition accounting and recorded a reduction to goodwill.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

The United States Centers for Medicare & Medicaid Services ("CMS") regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be

selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, the United States Department of Health and Human Services or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the United States Department of Justice (the "DOJ") in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. The consent decree remains subject to the court approval process under the Antitrust Procedures and Penalties Act, which could result in a revision in or delay in receiving approval of the consent decree. The approval process is for the limited purpose of determining whether the consent decree is in the public interest. The Company believes that the consent decree will not have a material impact on the Company's operating results, cash flows or financial condition.

Shareholder Matters

Between February and June 2019, five class action complaints were filed by putative plaintiffs against the Company and certain current and former officers and directors: *Anarkat v. CVS Health Corp., et al.,* Case No. 1:19-cv-01725 (S.D.N.Y.);
Labourers' Pension Fund of Central and Eastern Canada v. CVS Health Corp., et al., Case No. 651700/2019 (N.Y. Sup. Ct.);
City of Warren Police and Fire Retirement Sys.v. CVS Health Corp., et. al. , Case No. PC-2019-5658 (R.I. Super. Ct.); *Cambria Co. Employees Retirement Sys. v. CVS Health Corp., et al.* , Case No. 653223/2019 (N.Y. Sup. Ct.); and *Freundlich v. CVS Health Corp., et al* ., Case No. PC-2019-6685 (R.I. Super. Ct.). The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit, which allegedly injured investors who acquired CVS Health securities between May 21, 2015 and February 20, 2019. The *Freundlich* case also alleges that defendants misrepresented anticipated synergies of the Aetna Acquisition. The Company is defending itself against these claims.

Other Legal and Regulatory Proceedings .

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical or professional malpractice, claims processing, dispensing, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or

delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

12. Segment Reporting

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Effective for the first quarter of 2019, adjusted operating income is defined as operating income (loss) (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. Segment financial information for the three and six months ended June 30, 2018 has been retrospectively adjusted to conform with the current period presentation. See the reconciliation of consolidated operating income (loss) (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income (loss) in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

CVS 1st Quarter 2019 10-Q Legal Matters

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)
☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2019
or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to_____

Commission File Number: 001-01011

CVS HEALTH CORPORATION
(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	*(Zip Code)*

(401) 765-1500
(Registrant's telephone number, including area code)

Former name, former address and former fiscal year, if changed since last report: **N/A**

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ **Yes** ☑ **No**

There were 1,299,092,100 shares of the registrant's voting common stock with a par value of $0.01 per share outstanding at April 23, 2019.

related to Linens 'n Things, which have been recorded as a liability on the unaudited condensed consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies'

usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. The Company is defending itself against these claims.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. The *Corcoran* plaintiffs have appealed the District Court's decision to the Ninth Circuit. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. The Company has responded to the complaint, moved for judgment on the pleadings, filed a counterclaim and moved the case to Mississippi Circuit Court. The Company's motion for judgment on the pleadings remains pending. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

Bewley, et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases have been transferred to the U.S. District Court for the District of New Jersey on defendants' motions. In April 2019, the named plaintiffs in both the *Bewley* and *Prescott* cases voluntarily dismissed all of their claims without prejudice, ending both cases.

Klein , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation* . The Company is defending itself against these claims.

The Company has received subpoenas, CIDs, and other requests for documents and information from, and is being investigated by, Attorneys General of several states regarding its PBM practices, including pricing and rebates. In addition, the Company received an inquiry from the U.S. Senate Committee on Finance regarding insulin pricing. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). In some instances, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served the Company with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Omnicare pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Omnicare pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with

respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the trial arbitrator awarded the claimant hospitals approximately $150 million . Aetna appealed the trial arbitrator's decision. On March 28, 2019, the appellate arbitrator reduced the award to approximately $86 million . The proceeding has ended. During the three months ended March 31, 2019, the Company recorded the reduction in the required reserve amount for this proceeding as a measurement period adjustment to its Aetna Acquisition accounting and recorded a reduction to goodwill.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

The United States Centers for Medicare & Medicaid Services ("CMS") regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, the United States Department of Health and Human Services or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. The consent decree remains subject to the court approval process under the Antitrust Procedures and Penalties Act, which could result in a revision in or delay in receiving approval of the consent decree. The approval process is for the limited purpose of determining whether the consent decree is in the public interest. The Company believes that the consent decree will not have a material impact on the Company's operating results, cash flows or financial condition.

Shareholder Matters

In February and March 2019, two putative class action complaints were filed by putative plaintiffs against the Company and certain of its current and former officers. *Anarkat v. CVS Health Corp., et al.,* was filed in the U.S. District Court for the Southern District of New York, and *Labourers' Pension Fund of Central and Eastern Canada v. CVS Health Corp., et al.,* was filed in the Supreme Court of the State of New York, County of New York. The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit, which allegedly injured investors who acquired CVS Health securities between May 21, 2015 and February 20, 2019. The Company is defending itself against these claims.

Other Legal and Regulatory Proceedings .

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

12. Segment Reporting

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Effective for the first quarter of 2019, adjusted operating income is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. Segment financial information for the three months ended March 31, 2018 has been retrospectively adjusted to conform with the current period presentation. See the reconciliation of consolidated operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

CVS 2018 10-K Legal Matters

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

☑ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2018
OR
☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from _____ to_____
Commission file number 001-01011

CVSHealth

CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☑ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☑ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☑ Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑ Accelerated filer ☐
Non-accelerated filer ☐ Smaller reporting company ☐
Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). ☐ Yes ☑ No

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $65,262,991,789 as of June 30, 2018 , based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 19, 2019 , the registrant had 1,297,082,165 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Portions of the Annual Report to Stockholders for the fiscal year ended December 31, 2018 (the "Annual Report") are incorporated by reference in response to Items 1, 1A, 2 and 3 of Part I and Items 5, 6, 7, 7A, 8 and 9A of Part II, in each case to the extent described therein.

Information contained in the definitive proxy statement for CVS Health Corporation's 2019 Annual Meeting of Stockholders, to be filed on or about April 5, 2019 (the "Proxy Statement"), is incorporated by reference in response to Items 10 through 14 of Part III to the extent described therein.

to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of December 31, 2018, the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, Aetna recorded a discounted estimated liability and expense of $231 million pretax for its estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The Company did not record an asset for expected premium tax offsets for its in force business at December 31, 2018, as the amount was not material. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's results of operations, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The total guaranty fund assessments liability as of December 31, 2018 was $90 million and was recorded in accrued expenses on the consolidated balance sheet.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies' usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. The Company is defending itself against these claims.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. The *Corcoran* plaintiffs have appealed the District Court's decision to the Ninth Circuit. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. The Company has responded to the complaint, moved for judgment on the pleadings, filed a counterclaim and moved the case to Mississippi Circuit Court. The Company's motion for judgment on the pleadings remains pending. The Company is defending itself against these claims.

Manufacturer's Rebate Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning manufacturer's rebates that the Company has negotiated.

Bewley, et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases have been transferred to the U.S. District Court for the District of New Jersey on defendants' motions. The Company is defending itself against these claims.

Klein , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation* . The Company is defending itself against these claims.

In April 2017, the Company received a CID from the Attorney General of Washington requesting documents and information regarding pricing and rebates for insulin products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin pricing. The Office of the Attorney General of Washington has notified the Company that information provided in response to the Washington Attorney General's CID will be shared with the Attorneys General of California, Florida, Minnesota, New Mexico, the District of Columbia and Mississippi. In July 2017, the Company received a CID from the Attorney General of Minnesota requesting documents and information regarding pricing and rebates for insulin and epinephrine products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin and epinephrine pricing. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. Fewer than 100 similar cases that name the Company as a defendant in some capacity are pending in state courts. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). For several of these audits, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served Omnicare with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Company pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Company pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, Omnicare received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, Omnicare also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the arbitrator awarded the claimant hospitals approximately $150 million . The Company is defending itself against the claimant hospitals' claims and has appealed the arbitrator's decision.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's results of operations, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. The consent decree remains subject to the court approval process under the Antitrust Procedures and Penalties Act, which could result in a revision in or delay in receiving approval of the consent decree. The approval process is for the limited purpose of determining whether the consent decree is in the public interest. The Company believes that the consent decree will not have a material impact on the Company's results of operations, cash flows or financial condition.

Other Legal and Regulatory Proceedings .

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in the Company's Commercial Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's results of operations. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the

Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company currently has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information for which results of operations are evaluated on a regular basis by the Company's chief operating decision maker in deciding how to allocate resources and in assessing performance.

The Company evaluates its Pharmacy Services, Retail/LTC and Health Care Benefits segments' performance based on operating income (loss) and operating income (loss) before the effect of (i) nonrecurring charges or gains and (ii) certain intersegment activities. The chief operating decision maker does not use total assets by segment to make decisions regarding resources. Therefore the total asset disclosure by segment has not been included. See Note 1 "Significant Accounting Policies" for a description of the Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other segments and related significant accounting policies.

In 2018 , 2017 and 2016 , approximately 9.8% , 12.3% and 11.7% , respectively, of the Company's consolidated revenues were from Aetna, a Pharmacy Services segment client. On November 28, 2018, the Company completed the Aetna Acquisition. Subsequent to the Aetna Acquisition, transactions with Aetna will continue to be reported within the Pharmacy Services segment, but are eliminated in the Company's consolidated financial statements.

Effective for the first quarter of 2019, the Company will realign the composition of its segments to correspond with changes to its operating model. As a result of this realignment, the Company's Silverscript PDP will move from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company will move Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment.

Aetna 3rd Quarter 2018 10-Q Legal Matters

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2018

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to_____

Commission File Number: 1-16095



Aetna Inc.
(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code:	**(860) 273-0123**

Former name, former address and former fiscal year, if changed since last report: **N/A**

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ **Yes** ☑ **No**

There were 327.4 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at September 30, 2018.

14. Commitments and Contingencies

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner (the "Commissioner") placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, we recorded a discounted estimated liability and expense of $231 million pretax for our estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The undiscounted estimated liability was $347 million. The expense was recorded in operating expenses in our Consolidated Statements of Income, and the liability was recorded in accrued expenses and other current liabilities in our Consolidated Balance Sheets. We did not record an asset for expected premium tax offsets for our in force business at September 30, 2018, as the amount was not material. It is reasonably possible that in the future we may record a liability and expense relating to other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings
Out-of-Network Benefit Proceedings
We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from

participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. On June 30, 2018, the New Jersey District Court denied the plaintiffs' request for class certification of the plaintiffs' remaining claims. On October 4, 2018, the lead plaintiffs informed the New Jersey District Court that they would voluntarily dismiss their claims with prejudice. The New Jersey District Court and the parties will address any claims that remain after these dismissals.

On October 28, 2016, we were named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to our out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in our individual Public Exchange products from 2014 through 2016. Coverage under our individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the arbitrator awarded the claimant hospitals approximately $150 million. We intend to continue to defend ourselves vigorously against the claimant hospitals' claims and to appeal the arbitrator's decision.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The

Office of Inspector General (the "OIG") also is auditing our risk adjustment-related data and that of other companies. We expect CMS and the OIG to continue these types of audits.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and divested group insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and divested group insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, the OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the DOJ, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding the CVS Health Transaction, our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably

possible that we may incur liability related to those practices, whether as a result of litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulatory Proceedings", and it is reasonably possible that their outcome could be material to us.

15. Segment Information

Effective for the first quarter of 2018, we realigned our business segments to correspond with changes to our management structure and internal management reporting which reflect our evolving business strategy of helping our members live healthier lives. Refer to Note 1 for further discussion.

Non-GAAP financial measures we disclose, such as adjusted earnings and pre-tax adjusted earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. The chief executive officer assesses our consolidated results based on adjusted earnings and assesses business segment results based on pre-tax adjusted earnings because income taxes are recorded in our Corporate/Other category and are not allocated to our business operations.

Aetna 2nd Quarter 2018 10-Q Legal Matters

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2018

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to_____

Commission File Number: 1-16095



Aetna Inc.
(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code:	**(860) 273-0123**

Former name, former address and former fiscal year, if changed since last report: **N/A**

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ **Yes** ☑ **No**

There were 327.4 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at June 30, 2018.

14. Commitments and Contingencies

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner (the "Commissioner") placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, we recorded a discounted estimated liability and expense of $231 million pretax for our estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The undiscounted estimated liability was $347 million. The expense was recorded in operating expenses in our Consolidated Statements of Income, and the liability was recorded in accrued expenses and other current liabilities in our Consolidated Balance Sheets. We did not record an asset for expected premium tax offsets for our in force business at June 30, 2018 as the amount was not material. It is reasonably possible that in the future we may record a liability and expense relating to other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings
Out-of-Network Benefit Proceedings
We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from

participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. On June 30, 2018, the New Jersey District Court denied the plaintiffs' request for class certification of the plaintiffs' remaining claims. At present, the case is proceeding in the New Jersey District Court on behalf of the named plaintiffs only.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

The Centers for Medicare & Medicaid Services ("CMS") regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing our risk adjustment-related data and that of other companies. We expect CMS and the OIG to continue these types of audits.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to

predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and divested group insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and divested group insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, the OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the DOJ, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding the CVS Health Transaction, our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur liability related to those practices, whether as a result of litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products,

student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulatory Proceedings", and it is reasonably possible that their outcome could be material to us.

15. Segment Information

Effective for the first quarter of 2018, we realigned our business segments to correspond with changes to our management structure and internal management reporting which reflect our evolving business strategy of helping our members live healthier lives. Refer to Note 1 for further discussion.

Non-GAAP financial measures we disclose, such as adjusted earnings and pre-tax adjusted earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. The chief executive officer assesses our consolidated results based on adjusted earnings and assesses business segment results based on pre-tax adjusted earnings because income taxes are recorded in our Corporate/Other category and are not allocated to our business operations.

Summarized financial information of our segment operations[1] for the three and six months ended June 30, 2018 and 2017 were as follows:

(Millions)	Health Care	Corporate/Other	Total Company
Three Months Ended June 30, 2018			
Revenue from external customers	**$ 15,237**	**$ 141**	**$ 15,378**
Pre-tax adjusted earnings (loss)[2]	**1,602**	**(45)**	**1,557**
Three Months Ended June 30, 2017			
Revenue from external customers	$ 14,700	$ 561	$ 15,261
Pre-tax adjusted earnings (loss)[2]	1,774	(17)	1,757
Six Months Ended June 30, 2018			
Revenue from external customers	**$ 30,232**	**$ 278**	**$ 30,510**
Pre-tax adjusted earnings (loss)[2]	**3,088**	**(93)**	**2,995**
Six Months Ended June 30, 2017			
Revenue from external customers	$ 29,388	$ 1,111	$ 30,499
Pre-tax adjusted earnings (loss)[2]	3,255	(47)	3,208

(1) Total assets by segment are not disclosed as this information is not reviewed by the chief executive officer.

(2) Pre-tax adjusted earnings (loss) excludes net realized capital gains or losses, amortization of other acquired intangible assets and the other items described in the reconciliation below.

Aetna 1st Quarter 2018 10-Q Legal Matters

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)

☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2018

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to_____

Commission File Number: 1-16095



Aetna Inc.
(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code:	**(860) 273-0123**

Former name, former address and former fiscal year, if changed since last report: **N/A**

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ **Yes** ☑ **No**

There were 327.1 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at March 31, 2018.

13. Commitments and Contingencies

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner (the "Commissioner") placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, we recorded a discounted estimated liability and expense of $231 million pretax for our estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The undiscounted estimated liability was $347 million. The expense was recorded in operating expenses in our Consolidated Statements of Income, and the liability was recorded in accrued expenses and other current liabilities in our Consolidated Balance Sheets. We did not record an asset for expected premium tax offsets for our in force business at March 31, 2018 as the amount was not material. It is reasonably possible that in the future we may record a liability and expense relating to other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings
Out-of-Network Benefit Proceedings
We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from

participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. We intend to defend ourselves vigorously against the plaintiffs' remaining claims.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

The Centers for Medicare & Medicaid Services ("CMS") regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing our risk adjustment-related data and that of other companies. We expect CMS and the OIG to continue these types of audits.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or

adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings
We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and divested group insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and divested group insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, the OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the DOJ, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding the CVS Health Transaction, our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. As a result of these changes, in the fourth quarter of 2013, we increased our estimated liability for unpaid life insurance claims with respect to insureds who passed away on or before December 31, 2013, and recorded in current and future benefits a charge of $36 million ($55 million pretax). Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products,

student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulatory Proceedings", and it is reasonably possible that their outcome could be material to us.

14. Segment Information

Effective for the first quarter of 2018, we realigned our business segments to correspond with changes to our management structure and internal management reporting, which reflect our evolving business strategy of helping our members live healthier lives. Refer to Note 1 for further discussion.

Non-GAAP financial measures we disclose, such as adjusted earnings and pre-tax adjusted earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. The chief executive officer assesses our consolidated results based on adjusted earnings and assesses business segment results based on pre-tax adjusted earnings because income taxes are recorded in our Corporate/Other category and are not allocated to our business operations.

Summarized financial information of our segment operations[1] for the three months ended March 31, 2018 and 2017 were as follows:

(Millions)	Health Care	Corporate/Other	Total Company
Three Months Ended March 31, 2018			
Revenue from external customers	**$ 14,995**	**$ 137**	**$ 15,132**
Pre-tax adjusted earnings (loss)[2]	**1,486**	**(48)**	**1,438**
Three Months Ended March 31, 2017			
Revenue from external customers	$ 14,688	$ 550	$ 15,238
Pre-tax adjusted earnings (loss)[2]	1,481	(30)	1,451

(1) Total assets by segment are not disclosed as this information is not reviewed by the chief executive officer.
(2) Pre-tax adjusted earnings (loss) excludes net realized capital gains or losses, amortization of other acquired intangible assets and the other items described in the reconciliation below.

Aetna 2017 10-K Legal Matters

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2017

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to_____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☑ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☑ No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ Yes ☐ No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☑Yes ☐ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑ Accelerated filer ☐

Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). ☐ Yes ☑ No

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2017) was $49.2 billion.

liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

Out-of-Network Benefit Proceedings

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. We intend to defend ourselves vigorously against the plaintiffs' remaining claims.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other

litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing our risk adjustment-related data and that of other companies. We expect CMS and the OIG to continue these types of audits.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and

international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. As a result of these changes, in the fourth quarter of 2013, we increased our estimated liability for unpaid life insurance claims with respect to insureds who passed away on or before December 31, 2013, and recorded in current and future benefits a charge of $36 million ($55 million pretax). Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of further changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulatory Proceedings", and it is reasonably possible that their outcome could be material to us.

CVS 2017 10-K Legal Matters

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the fiscal year ended December 31, 2017

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the transition period from to

Commission file number 001-01011

CVSHealth

CVS HEALTH CORPORATION

(Exact name of Registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Exchange Act:

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Exchange Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $81,440,458,676 as of June 30, 2017, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 9, 2018, the registrant had 1,014,532,157 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2017 are incorporated by reference in our response to Items 7, 8 and 9 of Part II.

Information contained in our Proxy Statement for the 2018 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in income tax expense. The Company accrued interest expense of approximately $11 million in 2017, $10 million in 2016 and $5 million in 2015. The Company had approximately $34 million and $30 million accrued for interest and penalties as of December 31, 2017 and 2016, respectively.

There are no material uncertain tax positions as of December 31, 2017 the ultimate deductibility of which is highly certain but for which there is uncertainty about the timing.

As of December 31, 2017, the total amount of unrecognized tax benefits that, if recognized, would affect the effective income tax rate is approximately $317 million, after considering the federal benefit of state income taxes.

12 Commitments and Contingencies

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser has agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations. As of December 31, 2017, the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Legal Matters

The Company is a party to legal proceedings, investigations and claims in the ordinary course of its business, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial position.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters.

- *Indiana State District Council of Laborers and HOD Carriers Pension and Welfare Fund v. Omnicare, Inc.,* et al. (U.S. District Court for the Eastern District of Kentucky). In February 2006, two substantially similar putative class action lawsuits were filed and subsequently consolidated. The consolidated complaint was filed against Omnicare, three of its officers and two of its directors and purported to be brought on behalf of all open-market purchasers of Omnicare common stock from August 3, 2005 through July 27, 2006, as well as all purchasers who bought shares of Omnicare common stock in Omnicare's public offering in December 2005. The complaint alleged violations of the Securities Exchange Act of 1934 and Section 11 of the Securities Act of 1933 and sought, among other things, compensatory damages and injunctive relief. After dismissals and appeals to the United States Court of Appeals for the Sixth Circuit, the United States Supreme Court remanded the case to the district court. In October 2016, Omnicare filed an answer to plaintiffs' third amended complaint, and

discovery commenced. In August 2017, the plaintiffs moved for class certification, which Omnicare has opposed.

- *FTC and Multi-State Investigation.* In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the U.S. Federal Trade Commission ("FTC"). Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company has cooperated with the multi-state investigation.

- *United States* ex rel. *Jack Chin v. Walgreen Company,* et al. (U.S. District Court for the Central District of California). In March 2010, the Company received a subpoena from the U.S. Department of Health and Human Services, Office of the Inspector General requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to the Company's pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. In October 2016, the U.S. District Court for the Central District of California unsealed a *qui tam* complaint, filed in April 2009 against CVS Pharmacy and other retail pharmacies, alleging that the Company violated the federal False Claims Act, and the False Claims Acts of several states, by offering such programs. The complaint was served on the Company in January 2017. In December 2017, the same court unsealed a second *qui tam* complaint filed by the same relator in September 2017. The complaint is based on the same factual allegations but asserts a legal theory the Court did not permit him to add to the original case. The federal government has declined intervention in both cases. The Company is defending both lawsuits.

- *United States* ex rel. *Anthony R. Spay v. CVS Caremark Corporation,* et al. (U.S. District Court for the Eastern District of Pennsylvania). In January 2012, the court unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, Anthony Spay, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that CVS Caremark's processing of Medicare claims on behalf of one of its clients violated the federal False Claims Act. The United States declined to intervene in the lawsuit. In September 2015, the Court granted CVS Caremark's motion for summary judgment in its entirety, and entered judgment in favor of CVS Caremark and against Spay. Spay appealed. In December 2017, the United States Court of Appeals for the Third Circuit affirmed the court's judgment in favor of CVS Caremark.

- *State of Texas* ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation,* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands and has issued a series of subsequent requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the court unsealed a first amended petition. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to Texas Medicaid by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the usual and customary price. The amended petition was unsealed following the Company's filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County District Court), a declaratory judgment action against the State of Texas in December 2016 seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the Medicaid regulation. The State of Texas is also pursuing temporary injunctive relief.

- *Subpoena Concerning PBM Administrative Fees.* In March 2014, the Company received a subpoena from the United States Attorney's Office for the District of Rhode Island, requesting documents and information concerning bona fide service fees and rebates received from pharmaceutical manufacturers in connection with certain drugs utilized under Medicare Part D, as well as the reporting of those fees and rebates to Part D plan

sponsors. The Company has been cooperating with the government and providing documents and information in response to the subpoena.

- *Corcoran* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in United States District Court in the Northern District of California. Plaintiffs seek damages and injunctive relief on behalf of a class of consumers who purchased certain prescription drugs under the consumer protection statutes and common laws of certain states. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the consumer case (Corcoran), the Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. The plaintiffs have filed a notice of appeal to the Ninth Circuit. The Company continues to defend these actions.

- *Omnicare DEA Subpoena.* In September 2015, Omnicare was served with an administrative subpoena by the U.S. Drug Enforcement Administration ("DEA"). The subpoena seeks documents related to controlled substance policies, procedures, and practices at eight pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional pharmacy. The Company has been cooperating and providing documents in response to this administrative subpoena.

- *Omnicare Cycle Fill Civil Investigative Demand.* In October 2015, Omnicare received a Civil Investigative Demand from the United States Attorney's Office for the Southern District of New York requesting information and documents concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand. In July 2017, Omnicare also received a subpoena from the California Department of Insurance requesting documents on similar subject matter.

- *PBM Pricing Civil Investigative Demand.* In October 2015, the Company received from the U.S. Department of Justice (the "DOJ") a Civil Investigative Demand requesting documents and information in connection with a federal False Claims Act investigation concerning allegations that the Company submitted, or caused to be submitted, to the Medicare Part D program prescription drug event data that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *United States* ex rel. *Sally Schimelpfenig and John Segura v. Dr. Reddy's Laboratories Limited and Dr. Reddy's Laboratories, Inc.* (U.S. District Court for the Eastern District of Pennsylvania). In November 2015, the court unsealed a second amended *qui tam* complaint filed in September 2015. The DOJ declined to intervene in this action. The relators allege that the Company, Walgreens, Wal-Mart, and Dr. Reddy's Laboratories violated the federal and various state False Claims Acts by dispensing prescriptions in unit dose packaging supplied by Dr. Reddy's that was not compliant with the Consumer Product Safety Improvement Act and the Poison Preventive Packaging Act and thereby allegedly rendering the drugs misbranded under the Food, Drug and Cosmetic Act. In March 2017, the Court granted the Company's motion to dismiss with leave to file an amended complaint. In June 2017, the Company moved to dismiss relators' third amended complaint.

- *Barchock* et al. *v. CVS Health Corporation,* et al. (U.S. District Court for the District of Rhode Island). In February 2016, a class action lawsuit was filed against the Company, the Benefit Plans Committee of the Company, and Galliard Capital Management, Inc., by Mary Barchock, Thomas Wasecko, and Stacy Weller,

purportedly on behalf of the 401(k) Plan and the Employee Stock Ownership Plan of the Company (the "Plan"), and participants in the Plan. The complaint alleged that the defendants breached fiduciary duties owed to the plaintiffs and the Plan by investing too much of the Plan's Stable Value Fund in short-term money market funds and cash management accounts. The court recently granted the Company's motion to dismiss the plaintiffs' amended complaint. In May 2017, plaintiffs appealed that ruling in the United States Court of Appeals for the First Circuit.

- *State of California* ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined intervention in this case. The relator alleges that the Company submitted false claims for payment to California Medicaid in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer.

- *Retail DEA Matters.* The Company has been also undergoing several audits by the DEA Administrator and is in discussions with the DEA and the U.S. Attorney's Offices in several locations concerning allegations that the Company has violated certain requirements of the Controlled Substance Act.

- *National Opioid Litigation* . In December 2017, the United States Judicial Panel on Multidistrict Litigation ordered consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes, and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation is *In re National Prescription Opiate Litigation* (MDL No. 2804), pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes relevant federal court cases that name the Company, including actions filed by several counties in West Virginia; actions filed by several counties and cities in Michigan; actions filed by hospitals in Florida and Mississippi; and an action filed by the St. Croix Chippewa Indians of Wisconsin. Similar cases that name the Company in some capacity have been filed in state courts, including cases filed by Shelby County, Tennessee, *Shelby County (Tennessee) v. Purdue Pharma, L.P., et al.* (Shelby County Circuit Court, No. CT-004500-17), and several counties in West Virginia, *Brooke County (West Virginia) et al. v. Purdue Pharma, L.P., et al.* (Marshall County Circuit Court, Nos. 17-C-248 – 17-C-255). The Company is defending all such matters.

- *Cherokee Nation Opioid Litigation* . In April 2017, the Company was named as a defendant in an action filed on behalf of the Cherokee Nation in the District Court of Cherokee Nation (the "Cherokee Action") asserting various causes of action allegedly arising from the widespread abuse of opioids. In June 2017, the Company filed a motion to dismiss the Cherokee Action. The Cherokee Nation has since filed an amended petition in the Cherokee Action. Also in June 2017, the six defendants in the Cherokee Action collectively filed a complaint in the U.S. District Court for the Northern District of Oklahoma, *McKesson* , et al. *v. Hembree* , et al., seeking a declaration and preliminary injunction prohibiting the District Court of Cherokee Nation from exercising jurisdiction over the Cherokee Action. In January 2018, the U.S. District Court granted the preliminary injunction motion and issued an order enjoining the Cherokee Nation Attorney General and the judicial officers of the Cherokee Nation District Court from taking any action with respect to the Cherokee Action pending resolution of the federal court case.

- *State of Mississippi v. CVS Health Corporation,* et al. (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to Mississippi Medicaid by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. The Company has responded to the complaint, filed a counterclaim, and moved to transfer the case to circuit court. The motion to transfer was granted, which the State has appealed, and the motion to dismiss remains pending.

- *Part B Insulin Products Civil Investigative Demand.* In December 2016, the Company received a Civil Investigative Demand from the U.S. Attorney's Office for the Northern District of New York, requesting documents and information in connection with a False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Medicare Part D rather than Part B. The Company has cooperated with the government and provided documents and information in response to the Civil Investigative Demand.

- *Cold Chain Logistics Civil Investigative Demand* . In September 2016, the Company received from the DOJ a Civil Investigative Demand in connection with an investigation as to whether the Company's handling of certain temperature-sensitive pharmaceuticals violates the federal Food, Drug and Cosmetic Act and the False Claims Act. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *Amburgey,* et al. *v. CaremarkPCS Health, L.L.C.* (U.S. District Court for the Central District of California). In March 2017, the Company was served with a complaint challenging the policies and procedures used by CVS Specialty pharmacies to ship temperature-sensitive medications. The case is similar to a matter already pending against the Company in the Superior Court of California (Los Angeles County), *Bertram v. Immunex Corp.* , et al., which was filed in October 2014. In November 2017, the plaintiffs voluntarily dismissed the *Amburgey* case without prejudice. The Company continues to defend the Bertram matter.

- *Barnett,* et al. v. *Novo Nordisk Inc* ., et al. and *Boss* , et al. v. *CVS Health Corporation* , et al., and *Christensen,* et al., v. *Novo Nordisk Inc.* et al., (all pending in the U.S. District Court for the District of New Jersey). These putative class actions were filed against the Company and other PBMs and manufacturers of insulin in March and April 2017. Plaintiffs in all cases allege that the PBMs and manufacturers have engaged in a conspiracy whereby the PBMs sell access to their formularies by demanding the highest rebates, which in turn causes increased list prices for insulin. The primary claims are antitrust claims, claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), violations of state unfair competition and consumer protection laws and in *Boss* , claims pursuant to the Employee Retirement Income Security Act ("ERISA"). In December 2017, the attorney appointed as interim lead counsel in *Barnet, Boss* and *Christensen* filed a consolidated amended class action complaint in a related action, *In re Insulin Pricing Litigation* , against only the drug manufacturers, and not against the PBMs.

- *Insulin Products Investigation.* In April 2017, the Company received a Civil Investigative Demand from the Attorney General of Washington, seeking documents and information regarding pricing and rebates for insulin products in connection with a pending investigation into unfair and deceptive acts or practice regarding insulin pricing. We have been notified by the Office of the Attorney General of Washington that information provided in response to the Civil Investigative Demand will be shared with the Attorneys General of California, Florida, Minnesota, New Mexico and the District of Columbia. In July 2017, the Company received a Civil Investigative Demand from the Attorney General of Minnesota, seeking documents and information regarding pricing and rebates for insulin and epinephrine products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin and epinephrine pricing.

- *Bewley,* et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed in May 2017 against the Company and other pharmacy benefit managers and manufacturers of glucagon kits (Bewley) and diabetes test strips (Prescott). Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws, and ERISA. These cases have both been transferred to the United States District Court for the District of New Jersey on defendants' motions. The Company is defending these lawsuits.

- *Klein* , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). In June 2017, a putative class action complaint was filed against the Company and other pharmacy benefit managers on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the pharmacy benefit managers are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPen through the process of negotiating increased rebates from EpiPen manufacturer, Mylan. The Company is defending this lawsuit.

- *Medicare Part D Civil Investigative Demand* . In May 2017, the United States Attorney's Office for the Southern District of New York issued a Civil Investigative Demand to the Company concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *Shareholder Matters.* In August and September 2017, four complaints were filed by putative derivative plaintiffs against certain officers and directors of the Company. Three of those actions, *Sherman v. Merlo,* et al., *Feghali v. Merlo,* et al., and *Banchalter v. Merlo,* et al., were filed in the U.S. District Court for the District of Rhode Island. A fourth, *Boron v. Bracken,* et al., was filed in Rhode Island Superior Court. These matters assert a variety of causes of action, including breach of fiduciary duty, waste of corporate assets, unjust enrichment, civil conspiracy and violation of Section 14(a) of the Exchange Act, and are premised on the allegation that the defendants approved business plans that exposed the Company to various litigations and investigations. The three federal matters have been stayed pending resolution of certain of the underlying matters, and the Company has filed a motion to stay the state court action.

- *MSP Recovery Claims Series, LLC* , et al. v. *CVS Health Corporation* , et al. (U.S. District Court for the Western District of Texas). In September 2017, a putative class action complaint was filed against the company, Express Scripts, Inc., and the manufacturers of insulin on behalf of assignees of claims of Medicare Advantage Organizations. Plaintiffs assert that the PBMs and manufacturers have engaged in a conspiracy whereby the PBMs sell access to their formularies by demanding the highest rebates, which in turn causes increased list prices for insulin. The plaintiffs assert claims on behalf of two putative classes: (1) all Medicare C payors and (2) all Medicare D payors. The complaint asserts claims under RICO, and for common law fraud and unjust enrichment.

The Company is also a party to other legal proceedings, government investigations, inquiries and audits, and has received and is cooperating with subpoenas or similar process from various governmental agencies requesting information, all arising in the normal course of its business, none of which is expected to be material to the Company. The Company can give no assurance, however, that its business, financial condition and results of operations will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to the Company's business, the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industries or to the health care industry generally; (iii) pending or future federal or state governmental investigations of the Company's business or the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industry or of the health care industry generally; (iv) pending or future government enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industry or the health care industry generally.

Appendix D

Dun and Bradstreet Rating for CVS Health ..... App D-3

Dun and Bradstreet Rating for Coventry Health Care of West Virginia, Inc.
dba Aetna Better Health® of West Virginia..... App D-15

AM Best Press Release ..... App D-23

AM Best Press Release Rating Supplement ..... App D-29

Aetna Better Health® of West Virginia Capital Support Letter ..... App D-35

CVS 3rd Quarter 10-Q Filing ..... App D-39

Dun and Bradstreet Rating for CVS Health

DNBi Risk Management

Printed By:Jim null Bradford

Date Printed:January 3, 2020

LIVE REPORT

Currency: Shown in USD unless otherwise indicated

CVS HEALTH CORPORATION

Trade Names: CVS HEALTH

Do not confuse with subsidiaries with similar names.

ACTIVE HEADQUARTERS

D-U-N-S Number:
00-133-8912

Company:
CVS HEALTH CORPORATION

D&B Address

Address: 1 CVS DR
WOONSOCKET, RI, US - 02895

Location Type: HEADQUARTERS

Phone: 401-765-1500

Fax:

Web: www.cvshealth.com

Added to Portfolio: 01/31/2017

Endorsement: James.Bradford@CVSHealt

Last View Date: 01/03/2020

Company Summary

SCORE BAR

PAYDEX®	69	Paying 16 days past due
Commercial Credit Score Percentile	68	Moderate Risk of severe payment delinquency.
Financial Stress Score National Percentile	48	Moderate Risk of severe financial stress.
D&B Viability Rating	1 5 A B	View More Details
Bankruptcy Found	N	

D&B Rating	5A3	5A indicates 50 million and over, Credit appraisal of 3 is fair

D&B VIABILITY RATING SUMMARY

Viability Score

Viability Score : 1

Low Risk:1 ; High Risk:9

Data Depth Indicator

Data Depth Indicator : A

Predictive:A ; Descriptive:G

Portfolio Comparison

Portfolio Comparison : 5

Low Risk:1 ; High Risk:9

Company Profile:

B

Financial Data	Trade Payments	Company Size	Years in Business
Available	Available (3+Trade)	Large	Young

DETAILED TRADE RISK INSIGHT™

3 months from Nov-19 to Jan-20

Days Beyond Terms Past 3 months: 2 Days

Days Beyond Terms Past 3 months : 2

Low Risk:0 ; High Risk:120+

Dollar-weighted average of **126** payment experiences reported from **58** companies.

D&B COMPANY OVERVIEW

This is a headquarters location

Do not confuse with subsidiaries with similar names.

Branch(es) or Division(s) exist
Y

Gross Revenue
194579000000

Chief Executive
LARRY J MERLO, PRES-CEO

Age (Year Started)
57 years (1963)

Employees
295000 (280 Here)

History Status
CLEAR

Net Worth
58543000000

Financing
SECURED

Financial Condition
FAIR

Stock Symbol
CVS

SIC
5912 ,5961

Line of business
Pharmacy health care services

NAICS
446110

PAYDEX® TREND CHART

STOCK PERFORMANCE

CVS 73.66 -0.51 (-0.69%)

Previous Close: 74.17	Volume: 2,504,087.00
Daily High: 74.06	Daily Low: 73.07
52-Week High: 77.03	52-Week Low: 51.73
P/E: 21.9852	Market Cap: 95,815,999,116
EPS: 3.35	Div/Yield: 2.72

FIRSTRAIN COMPANY NEWS

Powered By FirstRain

Pharmacy Chains Could Reward Bottom Fishers in 2020 Investopedia.com Jan 3, 2020
Google Inc.

CVS Health Corp (NYSE:CVS) to Issue $0.50 Quarterly Dividend - Modern Readers MR Modern Readers Jan 3, 2020
Google Inc.

Retailer CVS closing 3 stores in P.R. following performance review News Is My Business Jan 3, 2020
Google Inc.

CVS Health declares $0.50 dividend One News Page Ltd Jan 2, 2020
Google Inc.

25,185 Shares in CVS Health Corp (NYSE:CVS) Acquired by Evoke Wealth LLC Tech Know Bits Jan 1, 2020
Google Inc.

CVS, Walmart expand recall of infants' ibuprofen WTVD ABC11 Dec 31, 2019
Google Inc.

CVS closing Norton Street location WHEC Dec 31, 2019
Google Inc.

CVS Health Corporation (NYSE:CVS) Might Not Be A Great Investment Wall Street Reporter, Inc. Dec 31, 2019
Google Inc.

CVS Health to Present at the 38th Annual J.P. Morgan Healthcare Conference PR Newswire Dec 31, 2019
Google Inc.

Bewildered CVS shoppers keep getting super-long receipts Courier Post Online Dec 30, 2019
Google Inc.

Declining to reweigh the evidence, Indiana Tax Court affirms assessments of CVS store based on cost approach JD Supra Dec 27, 2019
Google Inc.

CVS Health Corp (NYSE:CVS) Given Consensus Rating of ?Buy? by Brokerages Tech Know Bits Dec 27, 2019
Google Inc.

Juggling Responsibilities to Improve Business: a Q&A With GC of CVS Thomas Moriarty Corporate Counsel Dec 27, 2019
Google Inc.

Legislators question insurers about surprise billing practices Healthcare Finance News Dec 26, 2019
Google Inc.

Moving To The Sidelines On CVS Health Corporation Seeking Alpha Dec 25, 2019
Google Inc.

[December 26, 2019] Hedge Fund Favorites vs. CVS Caremark Corporation (CVS) In 2019 Trading Ideas Wall Street Reporter, Inc. Dec 25, 2019
Google Inc.

Is CVS Open On Christmas Day 2019? THE INQUISITR Dec 25, 2019
Google Inc.

CVS Health (CVS) Gains As Market Dips: What You Should Know NetDania Dec 24, 2019
Google Inc.

Barrington groups benefit from CVS Health Charity Classic East Bay RI Dec 24, 2019
Google Inc.

Health insurers and retail pharmacies are making a play for primary care Market Watch Dec 24, 2019
Google Inc.

CVS year in review: A timeline of key events Beckers Hospital Review Dec 23, 2019
Google Inc.

CVS Wants to Streamline Sleep Apnea Care [Editor's Message] Sleep Review Dec 23, 2019
Google Inc.

Cvs Health Corp $CVS Trading Report Stock Traders Daily Dec 23, 2019
Google Inc.

Maldon charity pledges to support workers' mental health maldon standard Dec 22, 2019
Google Inc.

Cvs Health Corp Has Returned 26.8% Since SmarTrend Recommendation (CVS) Barchart Dec 21, 2019
Google Inc.

CVS Health completes rollout of time-delay safes in all of its Virginia pharmacies Pharmacist.com Dec 20, 2019
Google Inc.

Analysis: CVS launches oncology program marrying precision medicine with care management Healthcare Financial Management Association Dec 20, 2019
Google Inc.

2019 CVS Health Charity Classic raises $1M Providence Business News Dec 19, 2019
Google Inc.

CVS Health Charity Classic Unveils $1 Million Donation to Local Non-Profits PR Newswire Dec 19, 2019
Google Inc.

The Laguna Drug building in downtown Laguna Beach. CVS has an application into the city to move into Los Angeles Times Dec 18, 2019
Google Inc.

CVS, Rite Aid join lawsuit over diabetes drug overcharging Modern Healthcare Dec 18, 2019
Google Inc.

CVS adds new security measure in Virginia, other states WDBJ7 Dec 18, 2019
Google Inc.

CVS Lawsuit: Why Is The Drugstore And Pharmacy Retailer Being Sued By The Government? International Business Times Dec 18, 2019
Google Inc.

Justice Department sues CVS over 'stale' Omnicare prescription refills Providence Journal Dec 18, 2019
Google Inc.

A CVS Lawsuit Uncovers Three Surprising Revelations about Amazon?s PillPack Strategy (rerun) Drug Channels Dec 18, 2019
Google Inc.

Independent pharmacies want Cuomo to sign bill they say could save their businesses SILive.com Dec 18, 2019
Google Inc.

CVS unveils new precision medicine initiative for oncology patients Pharmacist.com Dec 18, 2019
Google Inc.

AETNA Delivers Thousands of Letters to Macy?s Westfarms As Part of Believe Campaign Benefiting Make-A-Wish NorwalkPlus.com Dec 18, 2019
Google Inc.

Omnicare, CVS Health to ?vigorously defend itself? in DOJ fraud lawsuit McKnight's Long Term Care News Dec 17, 2019
Google Inc.

Pharmacy chain owned by CVS ran prescription scam: prosecutors NY Daily News Dec 17, 2019
Google Inc.

Federal Lawsuit Claims CVS Health/Omnicare Improperly Refilled Meds Across 3,000-Plus Senior Living Communities Senior Housing News Dec 17, 2019
Google Inc.

CVS long-term care pharmacy sued by DOJ over fraudulent prescribing practices Healthcare Dive Dec 17, 2019
Google Inc.

Justice Department joins litigation accusing CVS of fraudulently billling Medicare and other drug programs The Washington Post Dec 17, 2019
Google Inc.

DOJ sues CVS subsidiary for prescription drug fraud MedCity News Dec 17, 2019
Google Inc.

CVS faces federal lawsuit alleging fraudulent prescription drug billing AXIOS Dec 17, 2019
Google Inc.

DOJ sues Omnicare and parent CVS over alleged ?rollover? prescriptions for elderly and disabled Providence Business News Dec 17, 2019
Google Inc.

Dow Jones News: More Bad China News for Apple; Walgreens Down as CVS Sued Motley Fool Dec 17, 2019
Google Inc.

DOJ Joins Fraud Suit Against CVS, Omnicare HealthLeaders Media Dec 17, 2019
Google Inc.

CVS Health to provide $750K to California Harm Reduction Coalition Drug Store News Dec 17, 2019
Google Inc.

Evoke Wealth LLC Purchases New Position in CVS Health Corp (NYSE:CVS) Tech Know Bits Dec 17, 2019
Google Inc.

PUBLIC FILINGS

The following data includes both open and closed filings found in D&B's database on this company.

Record Type	Number of Records	Most Recent Filing Date
Bankruptcies	0	---
Judgments	2	01/30/2017
Liens	2	11/13/2013
Suits	29	12/20/2019
UCCs	5	06/12/2018

The public record items contained herein may have been paid, terminated, vacated or released prior to today's date.

Predictive Scores

D&B VIABILITY RATING SUMMARY

The D&B Viability Rating uses D&B's proprietary analytics to compare the most predictive business risk indicators and deliver a highly reliable assessment of the probability that a company will go out of business, become dormant/inactive, or file for bankruptcy/insolvency within the next 12 months. The D&B Viability Rating is made up of 4 components:

Viability Score
Compared to All US Businesses within the D&B Database:

- Level of Risk: **Low Risk**
- Businesses ranked 1 have a probability of becoming no longer viable: **0.2** %
- Percentage of businesses ranked **1**: **0.3** %
- Across all US businesses, the average probability of becoming no longer viable: **14** %

Portfolio Comparison
Compared to All US Businesses within the same MODEL SEGMENT:

- Model Segment : **Available Financial Data**
- Level of Risk: **Moderate Risk**
- Businesses ranked **5** within this model segment have a probability of becoming no longer viable: **0.5 %**
- Percentage of businesses ranked **5** with this model segment: **11** %
- Within this model segment, the average probability of becoming no longer viable: **0.6** %

Data Depth Indicator
Data Depth Indicator:

- ✓ Rich Firmographics
- ✓ Extensive Commercial Trading Activity
- ✓ Comprehensive Financial Attributes

Greater data depth can increase the precision of the D&B Viability Rating assessment.

Company Profile:
Company Profile Details:

- Financial Data: **Available**
- Trade Payments: **Available: 3+Trade**
- Company Size: **Large: Employees:50+ or Sales: $500K+**
- Years in Business: **Young: <5**

B

Financial Data	Trade Payments	Company Size	Years in Business
Available	Available: 3+Trade	Large	Young

To help improve the current data depth of this company, you can ask D&B to make a personalized request to this company on your behalf to obtain its latest financial information. To make the request, click the link below. Note, the company must be saved to a folder before the request can be made.

Request Financial Statements

Reference the FINANCIALS tab for this company to monitor the status of your request.

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Dun and Bradstreet Rating for Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia

DNBi Risk Management

Printed By:Jim null Bradford

Date Printed:January 6, 2020

LIVE REPORT

Currency: Shown in USD unless otherwise indicated

COVENTRY HEALTH CARE OF WEST VIRGINIA, INC.

Trade Names: (SUBSIDIARY OF CVS HEALTH CORPORATION, WOONSOCKET, RI),AETNA BETTER HEALTH OF WEST VIRGINIA

ACTIVE SINGLE (SUBSIDIARY)

D-U-N-S Number:
00-360-5944

Company:
COVENTRY HEALTH CARE OF WEST VIRGINIA, INC.

D&B Address

Address: 500 VIRGINIA ST E STE 400
CHARLESTON, WV, US - 25301

Location Type: SINGLE (SUBSIDIARY)

Phone: 304-348-2900

Fax:

Web: www.cvshealth.com

Endorsement: James.Bradford@CVSHealt

Company Summary

SCORE BAR

PAYDEX®		
Commercial Credit Score Percentile ↓	72	Low to Moderate Risk of severe payment delinquency.
Financial Stress Score National Percentile ↑	51	Moderate Risk of severe financial stress.
D&B Viability Rating	3 4 C Z	View More Details

Bankruptcy Found	N	
D&B Rating	--	Unavailable.

D&B VIABILITY RATING SUMMARY

Viability Score

Viability Score : 3

Low Risk:1 ; High Risk:9

Portfolio Comparison

Portfolio Comparison : 4

Low Risk:1 ; High Risk:9

Data Depth Indicator

Data Depth Indicator : C

Predictive:A ; Descriptive:G

Company Profile:

Z

SUBSIDIARY

DETAILED TRADE RISK INSIGHT™

3 months from to

D&B COMPANY OVERVIEW

This is a single (subsidiary) location

Chief Executive	Age (Year Started)	Employees
LAURIE ANN BRUBAKER, PRES	29 years (1991)	UNDETERMINED (Here)
History Status	**SIC**	**Line of business**
INCOMPLETE	8082	Home health care services

NAICS

621610

PUBLIC FILINGS

The following data includes both open and closed filings found in D&B's database on this company.

Record Type	Number of Records	Most Recent Filing Date
Bankruptcies	0	---
Judgments	0	---
Liens	0	---
Suits	0	---
UCCs	0	---

The public record items contained herein may have been paid, terminated, vacated or released prior to today's date.

CORPORATE LINKAGE

This is a Single (Subsidiary) location	COVENTRY HEALTH CARE OF WEST VIRGINIA, INC. Charleston, WV D-U-N-S® NUMBER: 00-360-5944
Parent Company	CVS HEALTH CORPORATION Rhode Island D-U-N-S® NUMBER: 00-133-8912

Predictive Scores

D&B VIABILITY RATING SUMMARY

The D&B Viability Rating uses D&B's proprietary analytics to compare the most predictive business risk indicators and deliver a highly reliable assessment of the probability that a company will go out of business, become dormant/inactive, or file for bankruptcy/insolvency within the next 12 months. The D&B Viability Rating is made up of 4 components:

Viability Score
Compared to All US Businesses within the D&B Database:

- Level of Risk: **Low Risk**
- Businesses ranked **3** have a probability of becoming no longer viable: **3** %
- Percentage of businesses ranked **3: 15** %
- Across all US businesses, the average probability of becoming no longer viable: **14** %

Portfolio Comparison
Compared to All US Businesses within the same MODEL SEGMENT:

- Model Segment : **Established Trade Payments**
- Level of Risk: **Low Risk**
- Businesses ranked **4** within this model segment have a probability of becoming no longer viable: **4 %**
- Percentage of businesses ranked **4** with this model segment: **11** %
- Within this model segment, the average probability of becoming no longer viable: **5** %

Data Depth Indicator
Data Depth Indicator:

- ✓ Rich Firmographics
- ✓ Extensive Commercial Trading Activity
- × No Financial Attributes

Greater data depth can increase the precision of the D&B Viability Rating assessment.

Company Profile:
Company Profile Details:

- Financial Data:
- Trade Payments:
- Company Size: **null**
- Years in Business: **null**

Subsidiary

To help improve the current data depth of this company, you can ask D&B to make a personalized request to this company on your behalf to obtain its latest financial information. To make the request, click the link below. Note, the company must be saved to a folder before the request can be made.

Request Financial Statements

Reference the FINANCIALS tab for this company to monitor the status of your request.

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AM Best Press Release

FOR IMMEDIATE RELEASE

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Director, Public Relations
+1 908 439 2200, ext. 5644
james.peavy@ambest.com

AM Best Affirms Credit Ratings of CVS Health Corporation's Aetna Subsidiaries

OLDWICK, N.J., November 21, 2019—AM Best has affirmed the Financial Strength Rating (FSR) of A (Excellent) and the Long-Term Issuer Credit Ratings (Long-Term ICR) of "a" of Aetna Life Insurance Company (ALIC) (Hartford, CT) and the other operating entities of Aetna Inc. that are now wholly-owned subsidiaries of CVS Health Corporation (CVS Health) [NYSE: CVS]. These entities include the members of Aetna Health & Life Group. Concurrently, AM Best has affirmed the FSR of A- (Excellent) and the Long-Term ICR of "a-" Aetna Insurance Company Limited (AICL) (United Kingdom). The outlook of these Credit Ratings (ratings) is stable.

AM Best also has affirmed the FSR of A (Excellent) and the Long-Term ICR of "a" of Texas Health + Aetna Health Insurance Company and Texas Health + Aetna Health Plan, Inc., (collectively Texas Health Aetna), and the Allina Health and Aetna Insurance Company, both of which are joint ventures with subsidiaries of Aetna Inc. The outlook of these ratings is stable.

Additionally, AM Best has withdrawn the FSR of A- (Excellent) and the Long-Term ICR of "a-" of Coventry Health Plan of Florida, Inc. (Coventry HP of FL) (Sunrise, FL) as the company ceased writing business.

Lastly, AM Best also has withdrawn the Long-Term ICR of "bbb", along with the Long Term Issue Credit Ratings (Long-Term IRs) and indicative Long-Term IRs on the universal shelf registration of Aetna Inc.

—MORE—

(headquartered in Hartford, CT). Following Aetna Inc.'s merger with a wholly-owned subsidiary of its ultimate parent, CVS Health, CVS Health assumed Aetna Inc.'s debt. Aetna Inc. no longer issues financial statements. (Please see link below for a detailed listing of the companies and ratings.)

The majority of Aetna's operating entities are part of the core subsidiaries of Aetna Inc. (Aetna Health & Life Group). The ratings of Aetna Health & Life Group reflect its balance sheet strength, which AM Best categorizes as very strong, as well as its strong operating performance, favorable business profile and appropriate enterprise risk management (ERM).

The ratings reflect Aetna Health & Life Group's very strong level of risk-adjusted capitalization, which is offset by a trend of high dividend payments that have exceeded $2 billion in each of the past three years, as the entities tend to dividend a large percentage of earnings. AM Best considers the group's operating performance to be strong with return on equity measures annually exceeding 20% and underwriting income greater than $2 billion per year. Aetna's parent, CVS Health, is projecting post-merger cost-savings synergies of at least $400 million in 2019 and approximately $800 million in additional savings forthcoming in 2020. Aetna Health & Life Group reported growth in net premiums in 2018 after a decline in 2017 and flat premium in the few years prior. AM Best notes that this group has reported consistent increase in Medicare Advantage premiums with double-digit growth. Some of this favorability is offset by losses in commercial fully insured business. Furthermore, SilverScript Insurance Company, a member of the Aetna Health & Life Group, remains the leading standalone Part D plan in the U.S. based on market share.

Aetna is one of the top health insurers in the U.S. market, and total medical membership has increased to 22.8 million individuals for commercial, Medicare and Medicaid products. Aetna's Medicare Advantage membership growth has outpaced the industry over the past five years, moving Aetna from the fifth to the third

position in the Medicare Advantage market. The share of members in plans with a Star rating of 4.5 or higher exceeds peers and the industry average. The company also has recently reported strong membership growth in Medicare Supplement and Medicaid managed care business. In 2019, membership in Aetna's commercial business has been relatively flat; however, it has reported a decline in its insured membership within that business, which has been partially offset by growth in its administrative services contract business.

The ratings of Aetna Health & Life Group reflect high financial leverage and goodwill at the ultimate parent, CVS Health. Financial leverage at the end of third quarter 2019 was approximately 52%. While that is considered high, it remains lower than year-end 2018 as the CVS Health organization is focused on de-leveraging. In addition, there is a significant execution risk related to the Aetna-CVS Health merger given the vertical nature of the transaction and potential complexity to achieve meaningful synergies. However, CVS Health stated its intention to maintain the current capitalization level at the insurance entities, which it has done. Furthermore, CVS Health has accelerated de-leveraging through robust cash flow and suspended its share repurchase program.

The ratings of AICL reflect its balance sheet strength, which AM Best categorizes as very strong, as well as its marginal operating performance, limited business profile and appropriate ERM. Furthermore, the ratings of AICL factor in rating enhancement from the Aetna organization. AICL has benefited from capital injections and the transfer of international business from the wider group.

The ratings of the Allina Health and Aetna Insurance Company joint venture reflect its balance sheet strength, which AM Best categorizes as very strong, as well as its marginal operating performance, limited business profile and appropriate ERM.

The ratings of Texas Health Aetna reflect its balance sheet strength, which AM Best categorizes as very strong, as well as its adequate operating performance, limited business profile and appropriate ERM.

A complete list of Aetna Inc.'s subsidiaries' FSRs, Long-Term ICRs and Long Term IRs also is available.

This press release relates to Credit Ratings that have been published on AM Best's website. For all rating information relating to the release and pertinent disclosures, including details of the office responsible for issuing each of the individual ratings referenced in this release, please see AM Best's Recent Rating Activity web page. For additional information regarding the use and limitations of Credit Rating opinions, please view Understanding Best's Credit Ratings. For information on the proper media use of Best's Credit Ratings and AM Best press releases, please view Guide for Media - Proper Use of Best's Credit Ratings and AM Best Rating Action Press Releases.

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AM Best Press Release Rating Supplement

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FOR IMMEDIATE RELEASE

November 21, 2019

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AM Best Affirms Credit Ratings of CVS Health Corporation's Aetna Subsidiaries

Ratings Supplement

The FSR of A (Excellent) and the Long-Term ICRs of "a" have been affirmed with a stable outlook for the following subsidiaries of Aetna Inc.:

- Aetna Life Insurance Company
- Aetna Health and Life Insurance Company
- Aetna Life & Casualty (Bermuda) Ltd.
- Aetna Health Inc. (a Connecticut corporation)
- Aetna Health Inc. (a Florida corporation)
- Aetna Health Inc. (a Georgia corporation)
- Aetna Health Inc. (a Louisiana corporation)
- Aetna Health Inc. (a New Jersey corporation)
- Aetna Health Inc. (a New York corporation)
- Aetna Health Inc. (a Maine Corporation)
- Aetna Health Inc. (a Pennsylvania corporation)
- Aetna Health Inc. (a Texas corporation)
- Aetna Health Insurance Company
- Aetna Health Insurance Company of New York
- Aetna Health of California Inc.
- Aetna Health of Iowa, Inc.
- Aetna Health of Utah, Inc.
- Aetna Dental of California Inc.
- Aetna Dental Inc. (a New Jersey corporation)
- Aetna Dental Inc. (a Texas corporation)
- American Continental Insurance Company
- Continental Life Insurance Company of Brentwood, Tennessee
- Coventry Health and Life Insurance Company
- Aetna Better Health of Michigan, Inc.

- Aetna Better Health of Missouri, LLC
- Coventry Health Care of Illinois, Inc.
- Coventry Health Care of Kansas, Inc.
- Coventry Health Care of Florida, Inc.
- Coventry Health Care of Missouri, Inc.
- Coventry Health Care of Nebraska, Inc.
- Coventry Health Care of Virginia, Inc.
- Coventry Health Care of West Virginia, Inc.
- First Health Life & Health Insurance Company
- HealthAssurance Pennsylvania, Inc.
- SilverScript Insurance Company
- Texas Health + Aetna Health Insurance Company
- Texas Health + Aetna Health Plan, Inc.
- Allina Health and Aetna Insurance Company

The FSR of A- (Excellent) and the Long-Term ICR of "a-" Aetna Insurance Company Limited have been affirmed with a stable outlook.

The FSR of A- (Excellent) and the Long-Term ICR of "a-" Coventry Health Plan of Florida, Inc. have been withdrawn.

The Long-Term ICR of "bbb" of Aetna Inc. has been withdrawn.

The following Long-Term IRs have been withdrawn:

Aetna Inc.—
-- "bbb" on $500 million 4.125% senior unsecured notes, due 2021
-- "bbb" on $1.0 billion 2.75% senior unsecured notes, due 2022
-- "bbb" on $1.3 billion 2.8% senior unsecured notes, due 2023
-- "bbb" on $750 million 3.5% senior unsecured notes, due 2024
-- "bbb" on $800 million 6.625% senior unsecured notes, due 2036
-- "bbb" on $700 million 6.75% senior unsecured notes, due 2037
-- "bbb" on $500 million 4.5% senior unsecured notes, due 2042
-- "bbb" on $500 million 4.125% senior unsecured notes, due 2042
-- "bbb" on $375 million 4.75% senior unsecured notes, due 2044
-- "bbb" on $1 billion 3.875% senior unsecured notes, due 2047
-- "bbb" on $600 million 5.45% senior unsecured notes, due 2021
(originally issued by Coventry Health Care, Inc.)

The following indicative Long-Term IRs on the universal shelf registration have been withdrawn:

Aetna Inc.—
-- "bbb" on senior unsecured debt
-- "bbb-" on subordinated debt
-- "bb+" on preferred stock

This press release relates to Credit Ratings that have been published on AM Best's website. For all rating information relating to the release and pertinent disclosures, including details of the office responsible for issuing each of the individual ratings referenced in this release, please see AM Best's Recent Rating Activity web page. For additional information regarding the use and limitations of Credit Rating opinions, please view Understanding Best's Credit Ratings. For information on the proper media use of Best's Credit Ratings and AM Best press releases, please view Guide for Media - Proper Use of Best's Credit Ratings and AM Best Rating Action Press Releases.

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Aetna Better Health® of West Virginia Capital Support Letter

aetna™

December 30, 2019

Coventry Health Care of West Virginia Inc. (dba Aetna Better Health of West Virginia)

Ladies and Gentlemen:

This letter confirms that Aetna Health Holdings, LLC (the "Parent") will provide financial support to Coventry Health Care of West Virginia Inc. (dba Aetna Better Health of West Virginia) (the "Company") sufficient for it to satisfy capital requirements and to remain in good standing with the State of West Virginia.

The Parent is currently an indirect parent of the Company and this shall remain in effect from the date of this letter, through and including June 30, 2021.

In addition, the undersigned represent that the Parent (or one or more of its affiliates) has the ability to provide the necessary financial support to the Company to the extent and when deemed necessary by the Company and that there are no restrictions on the Parent (or one or more of its affiliates) to provide such support.

Very Truly Yours,



Edward C. Lee
President and Secretary
Aetna Health Holdings, LLC

CVS 3rd Quarter 10-Q Filing

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

(Mark One)
☑ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended September 30, 2019
or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to_____

Commission File Number: 001-01011

CVSHealth

CVS HEALTH CORPORATION
(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(401) 765-1500**

Former name, former address and former fiscal year, if changed since last report: **N/A**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.01 per share	CVS	New York Stock Exchange

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). ☑ **Yes** ☐ **No**

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☑	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ **Yes** ☑ **No**

As of October 29, 2019, the registrant had 1,300,964,007 shares of common stock issued and outstanding.

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Part I. Financial Information

Item 1. Financial Statements

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CVS Health Corporation
Condensed Consolidated Statements of Operations
(Unaudited)

In millions, except per share amounts	Three Months Ended September 30, 2019	Three Months Ended September 30, 2018	Nine Months Ended September 30, 2019	Nine Months Ended September 30, 2018
Revenues:				
Products	$ 47,149	$ 46,334	$ 136,023	$ 136,035
Premiums	15,539	627	47,612	2,684
Services	1,859	308	5,447	951
Net investment income	263	221	805	485
Total revenues	64,810	47,490	189,887	140,155
Operating costs:				
Cost of products sold	40,437	39,502	116,654	115,883
Benefit costs	12,850	439	39,396	2,399
Goodwill impairment	—	—	—	3,921
Operating expenses	8,595	4,975	24,887	14,755
Total operating costs	61,882	44,916	180,937	136,958
Operating income	2,928	2,574	8,950	3,197
Interest expense	747	674	2,301	1,886
Loss on early extinguishment of debt	79	—	79	—
Other expense (income)	(31)	1	(93)	7
Income before income tax provision	2,133	1,899	6,663	1,304
Income tax provision	604	509	1,776	1,478
Income (loss) from continuing operations	1,529	1,390	4,887	(174)
Loss from discontinued operations, net of tax	—	—	—	(1)
Net income (loss)	1,529	1,390	4,887	(175)
Net loss attributable to noncontrolling interests	1	—	—	—
Net income (loss) attributable to CVS Health	$ 1,530	$ 1,390	$ 4,887	$ (175)
Basic earnings (loss) per share:				
Income (loss) from continuing operations attributable to CVS Health	$ 1.17	$ 1.36	$ 3.76	$ (0.17)
Loss from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —
Net income (loss) attributable to CVS Health	$ 1.17	$ 1.36	$ 3.76	$ (0.17)
Weighted average basic shares outstanding	1,302	1,020	1,300	1,018
Diluted earnings (loss) per share:				
Income (loss) from continuing operations attributable to CVS Health	$ 1.17	$ 1.36	$ 3.75	$ (0.17)
Loss from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —
Net income (loss) attributable to CVS Health	$ 1.17	$ 1.36	$ 3.75	$ (0.17)
Weighted average diluted shares outstanding	1,305	1,022	1,303	1,018
Dividends declared per share	$ 0.50	$ 0.50	$ 1.50	$ 1.50

See accompanying notes to condensed consolidated financial statements (unaudited).

CVS Health Corporation
Condensed Consolidated Statements of Comprehensive Income
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
In millions	**2019**	**2018**	**2019**	**2018**
Net income (loss)	$ 1,529	$ 1,390	$ 4,887	$ (175)
Other comprehensive income (loss), net of tax:				
Net unrealized investment gains	136	—	721	—
Foreign currency translation adjustments	153	(8)	157	(34)
Net cash flow hedges	(23)	(4)	(30)	335
Other comprehensive income (loss)	266	(12)	848	301
Comprehensive income	1,795	1,378	5,735	126
Comprehensive loss attributable to noncontrolling interests	1	—	—	—
Comprehensive income attributable to CVS Health	$ 1,796	$ 1,378	$ 5,735	$ 126

See accompanying notes to condensed consolidated financial statements (unaudited).

Index to Condensed Consolidated Financial Statements

CVS Health Corporation
Condensed Consolidated Balance Sheets
(Unaudited)

In millions, except per share amounts	September 30, 2019	December 31, 2018
Assets:		
Cash and cash equivalents	$ 5,193	$ 4,059
Investments	2,334	2,522
Accounts receivable, net	19,789	17,631
Inventories	16,028	16,450
Other current assets	4,841	4,581
Total current assets	48,185	45,243
Long-term investments	17,342	15,732
Property and equipment, net	11,651	11,349
Operating lease right-of-use assets	20,757	—
Goodwill	79,548	78,678
Intangible assets, net	33,655	36,524
Separate accounts assets	4,590	3,884
Other assets	4,385	5,046
Total assets	$ 220,113	$ 196,456
Liabilities:		
Accounts payable	$ 9,442	$ 8,925
Pharmacy claims and discounts payable	13,099	11,365
Health care costs payable	7,014	6,147
Policyholders' funds	2,938	2,939
Accrued expenses	11,615	10,711
Other insurance liabilities	1,790	1,937
Current portion of operating lease liabilities	1,798	—
Short-term debt	1,070	720
Current portion of long-term debt	3,778	1,265
Total current liabilities	52,544	44,009
Long-term operating lease liabilities	18,826	—
Long-term debt	64,206	71,444
Deferred income taxes	7,279	7,677
Separate accounts liabilities	4,590	3,884
Other long-term insurance liabilities	7,557	8,119
Other long-term liabilities	2,178	2,780
Total liabilities	157,180	137,913
Shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,725 shares issued and 1,301 shares outstanding at September 30, 2019 and 1,720 shares issued and 1,295 shares outstanding at December 31, 2018 and capital surplus	45,854	45,440
Treasury stock, at cost: 424 shares at September 30, 2019 and 425 shares at December 31, 2018	(28,207)	(28,228)
Retained earnings	44,017	40,911
Accumulated other comprehensive income	950	102
Total CVS Health shareholders' equity	62,614	58,225
Noncontrolling interests	319	318
Total shareholders' equity	62,933	58,543
Total liabilities and shareholders' equity	$ 220,113	$ 196,456

See accompanying notes to condensed consolidated financial statements (unaudited).

CVS Health Corporation
Condensed Consolidated Statements of Cash Flows
(Unaudited)

In millions	Nine Months Ended September 30, 2019	2018
Cash flows from operating activities:		
Cash receipts from customers	$ 184,519	$ 132,275
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(109,958)	(107,920)
Insurance benefits paid	(38,812)	(2,400)
Cash paid to other suppliers and employees	(21,411)	(12,305)
Interest and investment income received	756	406
Interest paid	(2,675)	(1,759)
Income taxes paid	(2,205)	(1,911)
Net cash provided by operating activities	10,214	6,386
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	5,616	43
Purchases of investments	(6,011)	(97)
Purchases of property and equipment	(1,890)	(1,452)
Acquisitions (net of cash acquired)	(361)	(616)
Proceeds from sale of subsidiary	—	725
Other	16	11
Net cash used in investing activities	(2,630)	(1,386)
Cash flows from financing activities:		
Net borrowings (repayments) of short-term debt	350	(1,276)
Proceeds from issuance of long-term debt	3,458	39,376
Repayments of long-term debt	(8,350)	(2,266)
Derivative settlements	(25)	446
Dividends paid	(1,952)	(1,528)
Proceeds from exercise of stock options	183	214
Payments for taxes related to net share settlement of equity awards	(85)	(39)
Other	11	—
Net cash provided by (used in) financing activities	(6,410)	34,927
Net increase in cash, cash equivalents and restricted cash	1,174	39,927
Cash, cash equivalents and restricted cash at the beginning of the period	4,295	1,900
Cash, cash equivalents and restricted cash at the end of the period	$ 5,469	$ 41,827

CVS Health Corporation
Condensed Consolidated Statements of Cash Flows
(Unaudited)

In millions	Nine Months Ended September 30, 2019	2018
Reconciliation of net income (loss) to net cash provided by operating activities:		
Net income (loss)	$ 4,887	$ (175)
Adjustments required to reconcile net income (loss) to net cash provided by operating activities:		
Depreciation and amortization	3,275	1,911
Goodwill impairment	—	3,921
Stock-based compensation	355	172
Loss on sale of subsidiary	205	86
Loss on early extinguishment of debt	79	—
Deferred income taxes and other noncash items	(38)	210
Change in operating assets and liabilities, net of effects from acquisitions:		
Accounts receivable, net	(2,312)	(1,725)
Inventories	413	472
Other assets	(374)	(3)
Accounts payable and pharmacy claims and discounts payable	2,330	1,839
Health care costs payable and other insurance liabilities	535	—
Other liabilities	859	(322)
Net cash provided by operating activities	$ 10,214	$ 6,386

See accompanying notes to condensed consolidated financial statements (unaudited).

CVS Health Corporation
Condensed Consolidated Statements of Shareholders' Equity
(Unaudited)

	Number of shares outstanding		Attributable to CVS Health						
In millions	Common Shares	Treasury Shares [1]	Common Stock and Capital Surplus [2]	Treasury Stock [1]	Retained Earnings	Accumulated Other Comprehensive Income	Total CVS Health Shareholders' Equity	Noncontrolling Interests	Total Shareholders' Equity
Balance at December 31, 2018	1,720	(425)	$ 45,440	$ (28,228)	$ 40,911	$ 102	$ 58,225	$ 318	$ 58,543
Adoption of new accounting standard (Note 1)	—	—	—	—	178	—	178	—	178
Net income	—	—	—	—	1,421	—	1,421	6	1,427
Other comprehensive income	—	—	—	—	—	331	331	—	331
Stock option activity, stock awards and other	2	—	175	—	—	—	175	—	175
Purchase of treasury shares, net of ESPP issuances	—	1	—	7	—	—	7	—	7
Common stock dividends	—	—	—	—	(651)	—	(651)	—	(651)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(4)	(4)
Balance at March 31, 2019	1,722	(424)	45,615	(28,221)	41,859	433	59,686	320	60,006
Net income (loss)	—	—	—	—	1,936	—	1,936	(5)	1,931
Other comprehensive income	—	—	—	—	—	251	251	—	251
Stock option activity, stock awards and other	2	—	104	—	—	—	104	—	104
Purchase of treasury shares, net of ESPP issuances	—	(1)	—	(36)	—	—	(36)	—	(36)
Common stock dividends	—	—	—	—	(659)	—	(659)	—	(659)
Other increases in noncontrolling interests	—	—	—	—	—	—	—	2	2
Balance at June 30, 2019	1,724	(425)	45,719	(28,257)	43,136	684	61,282	317	61,599
Net income (loss)	—	—	—	—	1,530	—	1,530	(1)	1,529
Other comprehensive income (Note 9)	—	—	—	—	—	266	266	—	266
Stock option activity, stock awards and other	1	—	135	—	—	—	135	—	135
Purchase of treasury shares, net of ESPP issuances	—	1	—	50	—	—	50	—	50
Common stock dividends	—	—	—	—	(649)	—	(649)	—	(649)
Other increases in noncontrolling interests	—	—	—	—	—	—	—	3	3
Balance at September 30, 2019	1,725	(424)	$ 45,854	$ (28,207)	$ 44,017	$ 950	$ 62,614	$ 319	$ 62,933

(1) Treasury shares includes 1 million shares held in trust and treasury stock includes $29 million related to shares held in trust as of September 30, 2019, June 30, 2019, March 31, 2019 and December 31, 2018.
(2) Common stock and capital surplus includes the par value of common stock of $17 million as of September 30, 2019, June 30, 2019, March 31, 2019 and December 31, 2018.

CVS Health Corporation
Condensed Consolidated Statements of Shareholders' Equity
(Unaudited)

	Number of shares outstanding		Attributable to CVS Health						
In millions	Common Shares	Treasury Shares [1]	Common Stock and Capital Surplus [2]	Treasury Stock [1]	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total CVS Health Shareholders' Equity	Noncontrolling Interests	Total Shareholders' Equity
Balance at December 31, 2017	1,712	(698)	$ 32,096	$ (37,796)	$ 43,556	$ (165)	$ 37,691	$ 4	$ 37,695
Adoption of new accounting standards [3]	—	—	—	—	(6)	(7)	(13)	—	(13)
Net income	—	—	—	—	998	—	998	—	998
Other comprehensive income	—	—	—	—	—	344	344	—	344
Stock option activity, stock awards and other	2	—	112	—	—	—	112	—	112
Purchase of treasury shares, net of ESPP issuances	—	—	—	49	—	—	49	—	49
Common stock dividends	—	—	—	—	(508)	—	(508)	—	(508)
Balance at March 31, 2018	1,714	(698)	32,208	(37,747)	44,040	172	38,673	4	38,677
Net loss	—	—	—	—	(2,563)	—	(2,563)	—	(2,563)
Other comprehensive loss	—	—	—	—	—	(31)	(31)	—	(31)
Stock option activity, stock awards and other	2	—	73	—	—	—	73	—	73
Purchase of treasury shares, net of ESPP issuances	—	(1)	—	(33)	—	—	(33)	—	(33)
Common stock dividends	—	—	—	—	(512)	—	(512)	—	(512)
Balance at June 30, 2018	1,716	(699)	32,281	(37,780)	40,965	141	35,607	4	35,611
Net income	—	—	—	—	1,390	—	1,390	—	1,390
Other comprehensive loss (Note 9)	—	—	—	—	—	(12)	(12)	—	(12)
Stock option activity, stock awards and other	1	—	96	—	—	—	96	—	96
Purchase of treasury shares, net of ESPP issuances	—	1	—	49	—	—	49	—	49
Common stock dividends	—	—	—	—	(512)	—	(512)	—	(512)
Balance at September 30, 2018	1,717	(698)	$ 32,377	$ (37,731)	$ 41,843	$ 129	$ 36,618	$ 4	$ 36,622

(1) Treasury shares include 1 million shares held in trust as of September 30, 2018, June 30, 2018, March 31, 2018 and December 31, 2017. Treasury stock includes $29 million related to shares held in trust as of September 30, 2018 and $31 million related to shares held in trust as of June 30, 2018, March 31, 2018 and December 31, 2017.
(2) Common stock and capital surplus includes the par value of common stock of $17 million as of September 30, 2018, June 30, 2018, March 31, 2018 and December 31, 2017.
(3) Reflects the adoption of Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers*, which resulted in a reduction to retained earnings of $13 million and the adoption of ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which resulted in a reduction to accumulated other comprehensive income of $7 million and an increase to retained earnings of $7 million, each during the three months ended March 31, 2018.

See accompanying notes to condensed consolidated financial statements (unaudited).

Notes to Condensed Consolidated Financial Statements

1. Significant Accounting Policies

Description of business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has approximately 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 102 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment.

Effective for the first quarter of 2019, the Company realigned the composition of its segments to correspond with changes to its operating model and reflect how its Chief Operating Decision Maker (the "CODM") reviews information and manages the business. As a result of this realignment, the Company's SilverScript® PDP moved from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company moved Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment. Segment financial information for the three and nine months ended September 30, 2018, has been retrospectively adjusted to reflect these changes.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below.

Pharmacy Services Segment
The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Retail/LTC Segment
The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. As of September 30, 2019, the Retail/LTC segment operated approximately 9,900 retail locations, approximately 1,100 MinuteClinic® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies.

Health Care Benefits Segment
The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of September 30, 2019. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation

administrative services and health information technology products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC."

Corporate/Other Segment
The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments and acquisition-related transaction and integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Basis of Presentation

The accompanying unaudited condensed consolidated financial statements of CVS Health Corporation and its subsidiaries have been prepared in accordance with the rules and regulations of the U.S. Securities and Exchange Commission (the "SEC") regarding interim financial reporting. In accordance with such rules and regulations, certain information and accompanying note disclosures normally included in financial statements prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") have been omitted, although the Company believes the disclosures included herein are adequate to make the information presented not misleading. These unaudited condensed consolidated financial statements should be read in conjunction with the audited consolidated financial statements and notes thereto for the year ended December 31, 2018, which were revised to reflect the Company's segment realignment and are included in Exhibit 99.2 to the Company's Current Report on Form 8-K filed with the SEC on August 8, 2019 (the "August 2019 8-K").

In the opinion of management, the accompanying unaudited condensed consolidated financial statements include all adjustments, consisting only of normal recurring adjustments, necessary for a fair presentation of the results for the interim periods presented. Because of the influence of various factors on the Company's operations, including business combinations, certain holidays and other seasonal influences, net income for any interim period may not be comparable to the same interim period in previous years or necessarily indicative of income for the full year.

Principles of Consolidation

The unaudited condensed consolidated financial statements include the accounts of CVS Health Corporation and its majority-owned subsidiaries and the variable interest entities ("VIEs") for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

The Company continually evaluates its investments to determine if they represent variable interests in a VIE. If the Company determines that it has a variable interest in a VIE, the Company then evaluates if it is the primary beneficiary of the VIE. The evaluation is a qualitative assessment as to whether the Company has the ability to direct the activities of a VIE that most significantly impact the entity's economic performance. The Company consolidates a VIE if it is considered to be the primary beneficiary.

Assets and liabilities of VIEs for which the Company is the primary beneficiary were not significant to the Company's unaudited condensed consolidated financial statements. VIE creditors do not have recourse against the general credit of the Company.

Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation.

Restricted Cash

Restricted cash included in other current assets in the unaudited condensed consolidated balance sheets represents amounts held in escrow accounts in connection with certain recent acquisitions. Restricted cash included in other assets in the unaudited

condensed consolidated balance sheets represents amounts held in a trust in one of the Company's captive insurance companies to satisfy collateral requirements associated with the assignment of certain insurance policies. All restricted cash is invested in time deposits, money market funds or commercial paper. The following represents a reconciliation of cash and cash equivalents in the unaudited condensed consolidated balance sheets to total cash, cash equivalents and restricted cash in the unaudited condensed consolidated statements of cash flows:

In millions	**September 30, 2019**	**December 31, 2018**
Cash and cash equivalents	$ 5,193	$ 4,059
Restricted cash (included in other current assets)	6	6
Restricted cash (included in other assets)	270	230
Total cash, cash equivalents and restricted cash in the statements of cash flows	$ 5,469	$ 4,295

Accounts Receivable

Accounts receivable are stated net of allowances for doubtful accounts, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net is composed of the following:

In millions	**September 30, 2019**	**December 31, 2018**
Trade receivables	$ 6,413	$ 6,497
Vendor and manufacturer receivables	9,029	7,315
Premium receivables	2,340	2,259
Other receivables	2,007	1,560
Total accounts receivable, net	$ 19,789	$ 17,631

Revenue Recognition

The following is a discussion of the Company's revenue recognition policies by segment.

Pharmacy Services Segment

The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Pharmacy Services segment, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the price paid to the Pharmacy Services segment by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("retail co-payments") and (iii) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenue.

The Company recognizes revenue when control of the prescription drugs is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those prescription drugs. The following revenue recognition policies have been established for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially

all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.

- Revenues generated from prescription drugs sold by third-party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

For contracts under which the Pharmacy Services segment acts as an agent or does not control the prescription drugs prior to transfer to the client plan member, revenue is recognized using the net method.

Drug Discounts

The Pharmacy Services segment records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand name formulary drugs. The Pharmacy Services segment estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Pharmacy Services segment adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues at the time it is identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's operating results or financial condition.

Guarantees

The Pharmacy Services segment also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to third party payers resulting from pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's operating results or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's operating results or financial condition. Sales taxes are not included in revenue.

Loyalty Program

The Company's customer loyalty program, ExtraCare®, consists of two components, ExtraSavings™ and ExtraBucks® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company has concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed ExtraBucks Rewards are reflected as a contract liability.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to receive in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of Long-term Care revenue from sales of pharmaceutical and medical products is reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as other third-party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's unaudited condensed consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third-party payors are typically not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third-party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment

Premium Revenue

Premiums are recognized as revenue in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (as amended, collectively, the "ACA's") minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the unaudited condensed consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services Revenue

Services revenue relates to contracts that can include various combinations of services or series of services which generally are capable of being distinct and accounted for as separate performance obligations. Health Care Benefits segment services revenue primarily consists of the following components:

- ASC fees are received in exchange for performing certain claim processing and member services for ASC members. ASC fee revenue is recognized over the period the service is provided. Some of the Company's administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, the Company is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period the Company estimates its obligations under the terms of these guarantees and records its estimate as an offset to services revenues.
- Workers' compensation administrative services consist of fee-based managed care services. Workers' compensation administrative services revenue is recognized once the service is provided.

Disaggregation of Revenue

The following tables disaggregate the Company's revenue by major source in each segment for the three and nine months ended September 30, 2019 and 2018:

In millions	Pharmacy Services	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
Three Months Ended September 30, 2019						
Major goods/services lines:						
Pharmacy	$ 35,872	$ 16,687	$ —	$ —	$ (10,007)	$ 42,552
Front Store	—	4,614	—	—	—	4,614
Premiums	—	—	15,507	32	—	15,539
Net investment income	—	—	146	117	—	263
Other	146	165	1,528	3	—	1,842
Total	$ 36,018	$ 21,466	$ 17,181	$ 152	$ (10,007)	$ 64,810
Pharmacy Services distribution channel:						
Pharmacy network [1]	$ 22,469					
Mail choice [2]	13,403					
Other	146					
Total	$ 36,018					
Three Months Ended September 30, 2018						
Major goods/services lines:						
Pharmacy	$ 33,733	$ 16,123	$ —	$ —	$ (8,088)	$ 41,768
Front Store	—	4,557	—	—	—	4,557
Premiums	—	—	627	—	—	627
Net investment income	—	—	4	217	—	221
Other	131	176	10	—	—	317
Total	$ 33,864	$ 20,856	$ 641	$ 217	$ (8,088)	$ 47,490
Pharmacy Services distribution channel:						
Pharmacy network [1]	$ 21,921					
Mail choice [2]	11,812					
Other	131					
Total	$ 33,864					

(1) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category.

(2) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a CVS Pharmacy retail store, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program, which permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order.

In millions	Pharmacy Services	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
Nine Months Ended September 30, 2019						
Major goods/services lines:						
Pharmacy	$ 103,983	$ 49,197	$ —	$ —	$ (31,436)	$ 121,744
Front Store	—	14,288	—	—	—	14,288
Premiums	—	—	47,543	69	—	47,612
Net investment income	—	—	458	347	—	805
Other	435	543	4,453	7	—	5,438
Total	$ 104,418	$ 64,028	$ 52,454	$ 423	$ (31,436)	$ 189,887
Pharmacy Services distribution channel:						
Pharmacy network [1]	$ 66,071					
Mail choice [2]	37,912					
Other	435					
Total	$ 104,418					
Nine Months Ended September 30, 2018						
Major goods/services lines:						
Pharmacy	$ 99,432	$ 47,428	$ —	$ —	$ (24,840)	$ 122,020
Front Store	—	13,990	—	—	—	13,990
Premiums	—	—	2,684	—	—	2,684
Net investment income	—	—	10	475	—	485
Other	405	542	29	—	—	976
Total	$ 99,837	$ 61,960	$ 2,723	$ 475	$ (24,840)	$ 140,155
Pharmacy Services distribution channel:						
Pharmacy network [1]	$ 64,625					
Mail choice [2]	34,807					
Other	405					
Total	$ 99,837					

(1) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice® activity, which is included within the mail choice category.

(2) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at a CVS Pharmacy retail store, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program, which permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order.

Contract Balances

Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, for example ExtraBucks Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers:

In millions	September 30, 2019	December 31, 2018
Trade receivables (included in accounts receivable, net)	$ 6,413	$ 6,497
Contract liabilities (included in accrued expenses)	72	67

During the nine months ended September 30, 2019, the contract liabilities balance includes increases related to customers' earnings in ExtraBucks Rewards or issuances of Company gift cards and decreases for revenues recognized during the period as a result of the redemption of ExtraBucks Rewards or Company gift cards and breakage of Company gift cards. Below is a summary of such changes:

In millions	
Balance at December 31, 2018	$ 67
Loyalty program earnings and gift card issuances	269
Redemption and breakage	(264)
Balance at September 30, 2019	$ 72

Related Party Transactions

The Company has an equity method investment in SureScripts, LLC ("SureScripts"). SureScripts operates a clinical health information network. The Company utilizes this clinical health information network in providing services to its client plan members and retail customers. The Company expensed fees for the use of this network of approximately $14 million and $4 million in the three months ended September 30, 2019 and 2018, respectively, and expensed fees for the use of this network of approximately $26 million and $34 million in the nine months ended September 30, 2019 and 2018, respectively. The Company's investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services ("Heartland"). Heartland operates several LTC pharmacies in four states. Heartland paid the Company approximately $20 million and $34 million for pharmaceutical inventory purchases during the three months ended September 30, 2019 and 2018, respectively, and $72 million and $105 million for pharmaceutical inventory purchases during the nine months ended September 30, 2019 and 2018, respectively. Additionally, the Company performs certain collection functions for Heartland and then passes those customer cash collections back to Heartland. The Company's investment in and equity in the earnings of Heartland for all periods presented is immaterial.

New Accounting Pronouncements Recently Adopted

Leases

In February 2016, the Financial Accounting Standards Board (the "FASB") issued ASU 2016-02, *Leases* (Topic 842). Under this accounting standard, lessees are required to recognize a right-of-use asset and a lease liability for virtually all of their leases (other than leases that meet the definition of a short-term lease). The liability is equal to the present value of lease payments. The asset is based on the liability, subject to certain adjustments, such as for initial direct costs. For income statement purposes, a dual model was retained, requiring leases to be classified as either operating or finance leases. Operating leases result in straight-line expense (similar to operating leases under the prior accounting standard) while finance leases result in a front-loaded expense pattern (similar to capital leases under the prior accounting standard). Lessor accounting is similar to the prior model, but updated to align with certain changes to the lessee model (e.g., certain definitions, such as initial direct costs, have been updated) and the new revenue recognition standard that was adopted in 2018.

The Company adopted this new accounting standard on January 1, 2019 on a modified retrospective basis and applied the new standard to all leases through a cumulative-effect adjustment to beginning retained earnings. As a result, comparative financial information has not been restated and continues to be reported under the accounting standards in effect for those periods. The Company elected the package of practical expedients permitted under the transition guidance within the new standard, which includes, among other things, the ability to carry forward the existing lease classification. On January 1, 2019, the Company recorded an after-tax transition adjustment to increase retained earnings by approximately $178 million ($241 million prior to tax effect). The new standard had a material impact on the unaudited condensed consolidated balance sheet, but did not materially impact the Company's consolidated operating results and had no impact on the Company's cash flows.

The following is a discussion of the Company's lease policy under the new lease accounting standard:

The Company determines if an arrangement contains a lease at the inception of a contract. Right-of-use assets represent the Company's right to use an underlying asset for the lease term and lease liabilities represent the Company's obligation to make lease payments arising from the lease. Right-of-use assets and lease liabilities are recognized at the commencement date based on the present value of the remaining future minimum lease payments. As the interest rate implicit in the Company's leases is not readily determinable, the Company utilizes its incremental borrowing rate, determined by class of underlying asset, to

discount the lease payments. The operating lease right-of-use assets also include lease payments made before commencement and exclude lease incentives.

The Company's real estate leases typically contain options that permit renewals for additional periods of up to five years each. For real estate leases, the options to extend are not considered reasonably certain at lease commencement because the Company reevaluates each lease on a regular basis to consider the economic and strategic incentives of exercising the renewal options and regularly opens or closes stores to align with its operating strategy. Generally, the renewal option periods are not included within the lease term and the associated payments are not included in the measurement of the right-of-use asset and lease liability. Similarly, renewal options are not included in the lease term for non-real estate leases because they are not considered reasonably certain of being exercised at lease commencement. Leases with an initial term of 12 months or less are not recorded on the balance sheets and lease expense is recognized on a straight-line basis over the term of the short-term lease.

For real estate leases, the Company accounts for lease components and nonlease components as a single lease component. Certain real estate leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred as variable lease costs. Other real estate leases contain one fixed lease payment that includes real estate taxes, common area maintenance and insurance. These fixed payments are considered part of the lease payment and included in the right-of-use assets and lease liabilities.

See Note 5 "Leases" for additional information.

Impact of New Lease Standard on Balance Sheet Line Items
As a result of applying the new lease accounting standard using a modified retrospective method, the following adjustments were made to accounts on the condensed consolidated balance sheet as of January 1, 2019:

		Impact of Change in Accounting Policy	
In millions	**As Reported December 31, 2018**	**Adjustments**	**As Adjusted January 1, 2019**
Condensed Consolidated Balance Sheets:			
Other current assets	$ 4,581	$ (48)	$ 4,533
Total current assets	45,243	(48)	45,195
Property and equipment, net	11,349	11	11,360
Operating lease right-of-use assets	—	20,987	20,987
Intangible assets, net	36,524	(217)	36,307
Other assets	5,046	(521)	4,525
Total assets	196,456	20,212	216,668
Accrued expenses	10,711	(52)	10,659
Current portion of operating lease liabilities	—	1,803	1,803
Current portion of long-term debt	1,265	2	1,267
Total current liabilities	44,009	1,753	45,762
Long-term operating lease liabilities	—	18,832	18,832
Long-term debt	71,444	(96)	71,348
Deferred income taxes	7,677	63	7,740
Other long-term liabilities	2,780	(518)	2,262
Total liabilities	137,913	20,034	157,947
Retained earnings	40,911	178	41,089
Total CVS Health shareholders' equity	58,225	178	58,403
Total shareholders' equity	58,543	178	58,721

Accounting for Interest Associated with the Purchase of Callable Debt Securities
In March 2017, the FASB issued ASU 2017-08, *Accounting for Interest Associated with the Purchase of Callable Debt Securities* (Topic 310). Under this standard, premiums on callable debt securities are amortized to the earliest call date rather than to the contractual maturity date. Callable debt securities held at a discount will continue to be amortized to the contractual maturity date. The Company adopted this new accounting standard on January 1, 2019 on a modified retrospective basis and

recorded an immaterial cumulative effect adjustment from accumulated other comprehensive income to retained earnings on the condensed consolidated balance sheet.

New Accounting Pronouncements Not Yet Adopted

Measurement of Credit Losses on Financial Instruments
In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326). This standard requires the use of a forward-looking expected loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments. This standard also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account and revises certain disclosure requirements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. The Company does not expect the implementation of this standard to have a material impact on the Company's consolidated operating results, cash flows, financial condition or related disclosures.

Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract
In August 2018, the FASB issued ASU 2018-15, *Intangibles - Goodwill and other - Internal-Use Software* (Topic 350-40): *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract.* This standard requires a customer in a cloud computing arrangement that is a service contract to follow the internal-use software guidance in Topic 350-40 to determine which implementation costs to capitalize as assets. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. The Company does not expect the implementation of this standard to have a material impact on the Company's consolidated operating results, cash flows, financial condition or related disclosures.

Targeted Improvements to the Accounting for Long-Duration Insurance Contracts
In August 2018, the FASB issued ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Contracts* (Topic 944). This standard requires the Company to review cash flow assumptions for its long-duration insurance contracts at least annually and recognize the effect of changes in future cash flow assumptions in net income. This standard also requires the Company to update discount rate assumptions quarterly and recognize the effect of changes in these assumptions in other comprehensive income. The rate used to discount the Company's liability for future policy benefits will be based on an estimate of the yield for an upper-medium-grade fixed-income instrument. In addition, this standard changes the amortization method for deferred acquisition costs and requires additional disclosures regarding the long duration insurance contract liabilities in the Company's interim and annual financial statements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2020. The Company is currently evaluating the effect that implementation of this standard will have on the Company's consolidated operating results, cash flows, financial condition and related disclosures.

2. Acquisition and Divestiture

Acquisition of Aetna

On the Aetna Acquisition Date, the Company acquired 100% of the outstanding shares and voting interests of Aetna for a combination of cash and stock. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans. Aetna is a leading health care benefits company that offers a broad range of traditional, voluntary, and consumer-directed health insurance products and related services. The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's approximately 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care.

The transaction has been accounted for using the acquisition method of accounting which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. The following table summarizes the estimated fair values of the assets acquired and liabilities assumed at the date of acquisition:

In millions	
Cash and cash equivalents	$ 6,565
Accounts receivable	4,094
Other current assets	3,894
Investments (current and long-term)	17,984
Goodwill	47,554
Intangible assets	22,571
Other long-term assets	8,249
Total assets acquired	110,911
Health care costs payable	5,302
Other current liabilities	10,069
Debt (current and long-term)	8,098
Deferred income taxes	4,278
Other long-term liabilities	13,078
Total liabilities assumed	40,825
Noncontrolling interests	320
Total consideration transferred	$ 69,766

The assessment of fair value is preliminary and is based on information that was available to management at the time the unaudited condensed consolidated financial statements were prepared. The most significant open item relates to the accounting for income taxes as management is awaiting additional information to complete its assessment. Measurement period adjustments will be recorded in the period in which they are determined, as if they had been completed at the acquisition date. Measurement period adjustments to assets acquired and liabilities assumed during the nine months ended September 30, 2019 primarily related to additional information received related to certain valuations and contingencies and the related impact on the accounting for income taxes and goodwill. There were no material income statement measurement period adjustments recorded during the three and nine months ended September 30, 2019.

Unaudited pro forma financial information

The following unaudited pro forma information presents a summary of the Company's combined operating results for the three and nine months ended September 30, 2018 as if the Aetna acquisition and the related financing transactions had occurred on January 1, 2017. The following pro forma financial information is not necessarily indicative of the Company's operating results as they would have been had the acquisition been effected on the assumed date, nor is it necessarily an indication of trends in future results for a number of reasons, including, but not limited to, differences between the assumptions used to prepare the pro forma information, basic shares outstanding and dilutive equivalents, cost savings from operating efficiencies, potential synergies and the impact of incremental costs incurred in integrating the businesses.

In millions, except per share amounts	**Three Months Ended September 30, 2018**	**Nine Months Ended September 30, 2018**
Total revenues	$ 60,865	$ 180,164
Income from continuing operations attributable to CVS Health	1,864	1,731
Basic earnings per share from continuing operations attributable to CVS Health	$ 1.44	$ 1.34
Diluted earnings per share from continuing operations attributable to CVS Health	$ 1.43	$ 1.33

The pro forma results for the three and nine months ended September 30, 2018 include adjustments related to the following purchase accounting and acquisition-related items:

- Elimination of intercompany transactions between CVS Health and Aetna;

- Elimination of estimated foregone interest income associated with (i) cash assumed to have been used to partially fund the Aetna Acquisition and (ii) adjusting the amortized cost of Aetna's investment portfolio to fair value as of the completion of the Aetna Acquisition;
- Elimination of historical intangible asset, deferred acquisition cost and capitalized software amortization expense and addition of amortization expense based on the current preliminary values of identified intangible assets;
- Additional interest expense from (i) the long-term debt issued to partially fund the Aetna Acquisition and (ii) the amortization of the fair value adjustment to assumed long-term debt.
- Additional depreciation expense related to the adjustment of Aetna's property and equipment to fair value;
- Adjustments to align CVS Health's and Aetna's accounting policies;
- Elimination of transaction related costs; and
- Tax effects of the adjustments noted above.

Divestiture of Brazilian Subsidiary

On July 1, 2019, the Company sold its Brazilian subsidiary, Drogaria Onofre Ltda. ("Onofre") for an immaterial amount. Onofre operates 50 retail pharmacy stores, the results of which have historically been reported within the Retail/LTC segment. The Company recorded a loss on the divestiture of $205 million in the three months ended September 30, 2019, which primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in operating expenses in the Company's unaudited condensed consolidated statements of operations within the Retail/LTC segment.

3. Investments

Total investments at September 30, 2019 and December 31, 2018 were as follows:

	September 30, 2019			December 31, 2018		
In millions	**Current**	**Long-term**	**Total**	**Current**	**Long-term**	**Total**
Debt securities available for sale	$ 2,175	$ 14,583	$ 16,758	$ 2,359	$ 12,896	$ 15,255
Mortgage loans	159	1,131	1,290	145	1,216	1,361
Other investments	—	1,628	1,628	18	1,620	1,638
Total investments	$ 2,334	$ 17,342	$ 19,676	$ 2,522	$ 15,732	$ 18,254

Debt Securities

Debt securities available for sale at September 30, 2019 and December 31, 2018 were as follows:

In millions	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
September 30, 2019				
Debt securities:				
U.S. government securities	$ 1,743	$ 83	$ —	$ 1,826
States, municipalities and political subdivisions	2,240	114	(1)	2,353
U.S. corporate securities	7,076	568	(7)	7,637
Foreign securities	2,095	194	—	2,289
Residential mortgage-backed securities	529	25	—	554
Commercial mortgage-backed securities	645	56	—	701
Other asset-backed securities	1,348	15	(5)	1,358
Redeemable preferred securities	32	8	—	40
Total debt securities [1]	$ 15,708	$ 1,063	$ (13)	$ 16,758
December 31, 2018				
Debt securities:				
U.S. government securities	$ 1,662	$ 26	$ —	$ 1,688
States, municipalities and political subdivisions	2,370	30	(1)	2,399
U.S. corporate securities	6,444	61	(16)	6,489
Foreign securities	2,355	31	(3)	2,383
Residential mortgage-backed securities	567	10	—	577
Commercial mortgage-backed securities	594	11	—	605
Other asset-backed securities	1,097	3	(15)	1,085
Redeemable preferred securities	30	—	(1)	29
Total debt securities [1]	$ 15,119	$ 172	$ (36)	$ 15,255

(1) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated operating results. At September 30, 2019, debt securities with a fair value of $973 million, gross unrealized capital gains of $85 million and no gross unrealized capital losses and at December 31, 2018, debt securities with a fair value of $916 million, gross unrealized capital gains of $12 million and gross unrealized capital losses of $2 million were included in total debt securities, but support experience-rated products. Changes in net unrealized capital gains (losses) on these securities are not reflected in accumulated other comprehensive income.

The fair value of debt securities at September 30, 2019 is shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	Amortized Cost	Fair Value
Due to mature:		
Less than one year	$ 1,017	$ 1,022
One year through five years	5,378	5,568
After five years through ten years	3,098	3,316
Greater than ten years	3,693	4,239
Residential mortgage-backed securities	529	554
Commercial mortgage-backed securities	645	701
Other asset-backed securities	1,348	1,358
Total	$ 15,708	$ 16,758

Summarized below are the debt securities the Company held at September 30, 2019 and December 31, 2018 that were in an unrealized capital loss position:

In millions, except number of securities	Number of Securities	Fair Value	Unrealized Losses
September 30, 2019			
Debt securities:			
U.S. government securities	8	$ 41	$ —
States, municipalities and political subdivisions	38	53	1
U.S. corporate securities	217	254	7
Foreign securities	27	39	—
Residential mortgage-backed securities	31	17	—
Other asset-backed securities	327	386	5
Total debt securities	648	$ 790	$ 13
December 31, 2018			
Debt securities:			
U.S. government securities	8	$ 26	$ —
States, municipalities and political subdivisions	54	86	1
U.S. corporate securities	1,399	1,431	16
Foreign securities	243	314	3
Residential mortgage-backed securities	45	1	—
Other asset-backed securities	516	528	15
Redeemable preferred securities	14	23	1
Total debt securities	2,279	$ 2,409	$ 36

Since Aetna's investment portfolio was measured at fair value as of the Aetna Acquisition Date, each of the securities in the table above were in an unrealized loss position for less than 12 months. The Company reviewed the securities in the table above and concluded that these are performing assets generating investment income to support the needs of the Company's business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. As of September 30, 2019, the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at September 30, 2019 were as follows:

	Supporting experience-rated products		Supporting remaining products		Total	
In millions	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Due to mature:						
Less than one year	$ —	$ —	$ 3	$ —	$ 3	$ —
One year through five years	1	—	137	2	138	2
After five years through ten years	8	—	128	4	136	4
Greater than ten years	11	—	99	2	110	2
Residential mortgage-backed securities	—	—	17	—	17	—
Other asset-backed securities	10	—	376	5	386	5
Total	$ 30	$ —	$ 760	$ 13	$ 790	$ 13

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. The Company did not have any mortgage loans during the three and nine months ended September 30, 2018. During the three and nine months ended September 30, 2019, the Company had the following activity in its mortgage loan portfolio:

In millions	Three Months Ended September 30, 2019	Nine Months Ended September 30, 2019
New mortgage loans	$ 12	$ 90
Mortgage loans fully repaid	56	127
Mortgage loans foreclosed	—	—

The Company assesses mortgage loans on a regular basis for credit impairments and annually assigns a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan to value ratios, property condition, market trends, creditworthiness of the borrower and deal structure. The vast majority of the Company's mortgage loans fall into categories 2 to 4.

- *Category 1* - Represents loans of superior quality.
- *Categories 2 to 4* - Represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represent loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the Company's assessments at September 30, 2019 and December 31, 2018, the Company's mortgage loans were given the following credit quality indicators:

In millions, except credit ratings indicator	September 30, 2019	December 31, 2018
1	$ 44	$ 42
2 to 4	1,234	1,301
5 and 6	12	18
7	—	—
Total	$ 1,290	$ 1,361

Net Investment Income

Sources of net investment income for the three and nine months ended September 30, 2019 and 2018 were as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
In millions	**2019**	**2018**	**2019**	**2018**
Debt securities	$ 145	$ 2	$ 437	$ 5
Mortgage loans	19	—	54	—
Other investments	60	219	163	480
Gross investment income	224	221	654	485
Investment expenses	(10)	—	(28)	—
Net investment income (excluding net realized capital gains or losses)	214	221	626	485
Net realized capital gains (1)	49	—	179	—
Net investment income (2)	$ 263	$ 221	$ 805	$ 485

(1) Other-than-temporary impairment ("OTTI") losses on debt securities recognized in the unaudited condensed consolidated statements of operations were $9 million and $22 million, respectively, for the three and nine months ended September 30, 2019. There were no OTTI losses on debt securities for the three and nine months ended September 30, 2018.

(2) Net investment income includes $10 million and $33 million for the three and nine months ended September 30, 2019, respectively, related to investments supporting experience-rated products. The Company had no investments supporting experience-rated products during the three and nine months ended September 30, 2018.

The portion of unrealized capital gains and losses recognized during the three and nine months ended September 30, 2019 related to investments in equity securities held as of the reporting date was not material.

The Company did not have any material proceeds from the sale of available for sale debt securities or related gross realized capital gains or losses for the three and nine months ended September 30, 2018. Excluding amounts related to experience-rated products, proceeds from the sale of available for sale debt securities and the related gross realized capital gains and losses for the three and nine months ended September 30, 2019 were as follows:

In millions	Three Months Ended September 30, 2019	Nine Months Ended September 30, 2019
Proceeds from sales	$ 1,325	$ 4,087
Gross realized capital gains	55	127
Gross realized capital losses	9	13

4. Fair Value

The preparation of the Company's condensed consolidated financial statements in accordance with GAAP requires certain assets and liabilities to be reflected at their fair value and others to be reflected on another basis, such as an adjusted historical cost basis. The Company's assets and liabilities carried at fair value have been classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("valuation inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Valuation inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, valuation inputs that are observable that are not prices (such as interest rates and credit risks) and valuation inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

For a description of the methods and assumptions that are used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument, see Note 4 "Fair Value" contained in the "Notes to Consolidated Financial Statements" in Exhibit 99.2 to the August 2019 8-K.

There were no financial liabilities measured at fair value on a recurring basis on the condensed consolidated balance sheets at September 30, 2019 or December 31, 2018. Financial assets measured at fair value on a recurring basis on the condensed consolidated balance sheets at September 30, 2019 and December 31, 2018 were as follows:

In millions	Level 1	Level 2	Level 3	Total
September 30, 2019				
Debt securities:				
U.S. government securities	$ 1,746	$ 80	$ —	$ 1,826
States, municipalities and political subdivisions	—	2,353	—	2,353
U.S. corporate securities	—	7,596	41	7,637
Foreign securities	—	2,284	5	2,289
Residential mortgage-backed securities	—	554	—	554
Commercial mortgage-backed securities	—	701	—	701
Other asset-backed securities	—	1,358	—	1,358
Redeemable preferred securities	—	28	12	40
Total debt securities	1,746	14,954	58	16,758
Equity securities	32	—	36	68
Total	$ 1,778	$ 14,954	$ 94	$ 16,826
December 31, 2018				
Debt securities:				
U.S. government securities	$ 1,597	$ 91	$ —	$ 1,688
States, municipalities and political subdivisions	—	2,399	—	2,399
U.S. corporate securities	—	6,422	67	6,489
Foreign securities	—	2,380	3	2,383
Residential mortgage-backed securities	—	577	—	577
Commercial mortgage-backed securities	—	605	—	605
Other asset-backed securities	—	1,085	—	1,085
Redeemable preferred securities	—	22	7	29
Total debt securities	1,597	13,581	77	15,255
Equity securities	19	—	54	73
Total	$ 1,616	$ 13,581	$ 131	$ 15,328

There were no transfers between Levels 1 and 2 during the three and nine months ended September 30, 2019 or 2018. During the three and nine months ended September 30, 2019 and 2018, there were no transfers into or out of Level 3.

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the condensed consolidated balance sheets at adjusted cost or contract value at September 30, 2019 and December 31, 2018 were as follows:

In millions	Carrying Value	Estimated Fair Value			
		Level 1	Level 2	Level 3	Total
September 30, 2019					
Assets:					
Mortgage loans	$ 1,290	$ —	$ —	$ 1,317	$ 1,317
Equity securities [1]	142	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	372	—	—	385	385
Long-term debt	67,984	72,823	—	—	72,823
December 31, 2018					
Assets:					
Mortgage loans	$ 1,361	$ —	$ —	$ 1,366	$ 1,366
Equity securities [1]	140	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	382	—	—	357	357
Long-term debt	72,709	71,252	—	—	71,252

(1) It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies.

Separate Accounts assets related to the Company's large case pensions products represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Separate Accounts financial assets as of September 30, 2019 and December 31, 2018 were as follows:

In millions	September 30, 2019				December 31, 2018			
	Level 1	Level 2	Level 3	Total	Level 1	Level 2	Level 3	Total
Debt securities	$ 1,207	$ 2,609	$ —	$ 3,816	$ 782	$ 2,500	$ 4	$ 3,286
Equity securities	—	2	—	2	—	3	—	3
Common/collective trusts	—	513	—	513	—	404	—	404
Total [1]	$ 1,207	$ 3,124	$ —	$ 4,331	$ 782	$ 2,907	$ 4	$ 3,693

(1) Excludes $259 million and $191 million of cash and cash equivalents and accounts receivable at September 30, 2019 and December 31, 2018, respectively.

During the three and nine months ended September 30, 2019, the Company had an immaterial amount of Level 3 Separate Accounts financial assets.

5. Leases

The Company leases most of its retail stores and mail order facilities and certain distribution centers and corporate offices under operating or finance leases, typically with initial terms of 15 to 25 years. The Company also leases certain equipment and other assets under operating or finance leases, typically with initial terms of 3 to 10 years.

The Company maintains certain lease agreements for which the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings being leased. For these pharmacy lease agreements, the Company concluded that for accounting purposes the lease term was the remaining economic life of the buildings. Consequently, most of these individual pharmacy leases are finance leases.

The following table is a summary of the Company's components of net lease cost for the three and nine months ended September 30, 2019:

In millions	**Three Months Ended September 30, 2019**	**Nine Months Ended September 30, 2019**
Operating lease cost	$ 681	$ 2,044
Finance lease cost:		
Amortization of right-of-use assets	9	27
Interest on lease liabilities	11	32
Total finance lease costs	20	59
Short-term lease costs	5	17
Variable lease costs	148	434
Less: sublease income	13	35
Net lease cost	$ 841	$ 2,519

Supplemental cash flow information related to leases for the nine months ended September 30, 2019 is as follows:

In millions	
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows paid for operating leases	$ 2,023
Operating cash flows paid for interest portion of finance leases	32
Financing cash flows paid for principal portion of finance leases	19
Right-of-use assets obtained in exchange for lease obligations:	
Operating leases	1,203
Finance leases	82

Supplemental balance sheet information related to leases as of September 30, 2019 is as follows:

In millions, except lease term and discount rate	
Operating leases:	
Operating lease right-of-use assets	$ 20,757
Current portion of operating lease liabilities	$ 1,798
Long-term operating lease liabilities	18,826
Total operating lease liabilities	$ 20,624
Finance leases: [1]	
Property and equipment, net	$ 560
Current portion of long-term debt	$ 27
Long-term debt	591
Total finance lease liabilities	$ 618
Weighted average remaining lease term	
Operating leases	13.8
Finance leases	20.6
Weighted average discount rate	
Operating leases	4.6%
Finance leases	7.3%

(1) Finance lease right-of-use assets are included within property and equipment, net and the respective finance lease liabilities are included in current portion of long-term debt and long-term debt on the unaudited condensed consolidated balance sheets.

The following table summarizes the maturity of lease liabilities under finance and operating leases as of September 30, 2019:

In millions	Finance Leases	Operating Leases [1]	Total
2019 (remaining three months)	$ 18	$ 679	$ 697
2020	70	2,688	2,758
2021	68	2,567	2,635
2022	64	2,408	2,472
2023	62	2,297	2,359
Thereafter	883	17,165	18,048
Total lease payments [2]	1,165	27,804	28,969
Less: imputed interest	(547)	(7,180)	(7,727)
Total lease liabilities	$ 618	$ 20,624	$ 21,242

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $320 million due in the future under noncancelable subleases.
(2) The Company leases pharmacy and clinic space from Target Corporation. Amounts related to such finance and operating leases are reflected above. Pharmacy lease amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.3 billion are not reflected in this table since the estimated economic life of the buildings is shorter than the contractual term of the pharmacy lease arrangement.

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the table above. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. Sale-leaseback transactions resulted in an

immaterial gain and proceeds of $5 million in the nine months ended September 30, 2019. There were no sale-leaseback transactions in the three months ended September 30, 2019 or the three and nine months ended September 30, 2018.

Store Rationalization Charges

During the first quarter of 2019, the Company performed a review of its retail stores and determined it would close 46 underperforming retail pharmacy stores during the second quarter of 2019. As a result, management determined that there were indicators of impairment with respect to the impacted stores, including the associated operating lease right-of-use assets. Accordingly, an interim long-lived asset impairment test was performed. The results of the impairment test indicated that the fair value of each store asset group was lower than the carrying value. The fair value was determined using a discounted cash flow method based on estimated sublease income. In the three months ended March 31, 2019, the Company recorded a store rationalization charge of $135 million, primarily related to these operating lease right-of-use asset impairment charges, which was recorded within operating expenses in the Retail/LTC segment.

During the third quarter of 2019, in connection with its annual budgeting process, the Company performed an updated review of its retail stores and determined it would close an additional 22 underperforming retail pharmacy stores during the first quarter of 2020. As a result, management determined that there were indicators of impairment with respect to the impacted stores, including the associated operating lease right-of-use assets. Accordingly, an interim long-lived asset impairment test was performed. The results of the impairment test indicated that the fair value of each store asset group was lower than the carrying value. The fair value was determined using a discounted cash flow method based on estimated sublease income. In the three months ended September 30, 2019, the Company recorded a store rationalization charge of $96 million, primarily related to these operating lease right-of-use asset impairment charges, which was recorded within operating expenses in the Retail/LTC segment.

6. Health Care Costs Payable

Prior to the Aetna Acquisition, the Company's health care costs payable balance was immaterial and related to unpaid pharmacy claims for its SilverScript PDP. Accordingly, the Company has not included disclosures for health care costs payable for periods prior to the Aetna Acquisition Date.

The following table shows the components of the change in health care costs payable during the nine months ended September 30, 2019:

In millions	
Health care costs payable, beginning of the period	$ 6,147
Less: Reinsurance recoverables	4
Health care costs payable, beginning of the period, net	6,143
Add: Components of incurred health care costs	
Current year	39,657
Prior years	(511)
Total incurred health care costs [1]	39,146
Less: Claims paid	
Current year	33,032
Prior years	5,253
Total claims paid	38,285
Add: Premium deficiency reserve	6
Health care costs payable, end of period, net	7,010
Add: Reinsurance recoverables	4
Health care costs payable, end of period	$ 7,014

(1) Total incurred health care costs during the nine months ended September 30, 2019 in the table above exclude (i) $6 million related to a premium deficiency reserve for the 2019 coverage year related to the Company's Medicaid products, (ii) $31 million of benefit costs recorded in the Health Care Benefits segment that are included in other insurance liabilities on the unaudited condensed consolidated balance sheet and (iii) $213 million of benefit costs recorded in the Corporate/Other segment that are included in other insurance liabilities on the unaudited condensed consolidated balance sheet.

The Company's estimates of prior years' health care costs payable decreased by $511 million in the nine months ended September 30, 2019, because claims were settled for amounts less than originally estimated (i.e., the amount of claims incurred was lower than originally estimated), primarily due to lower health care cost trends as well as the actual claim submission time being faster than originally assumed (i.e., the Company's completion factors were higher than originally assumed) in estimating health care costs payable at the end of the prior year.

At September 30, 2019, the Company's liabilities for the ultimate cost of (i) services rendered to members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid (collectively, "IBNR") plus expected development on reported claims totaled approximately $5.0 billion. Substantially all of the Company's liabilities for IBNR plus expected development on reported claims at September 30, 2019 related to the current year.

7. Borrowings

The following table is a summary of the Company's borrowings at September 30, 2019 and December 31, 2018:

In millions	September 30, 2019	December 31, 2018
Short-term debt		
Commercial paper	$ 1,070	$ 720
Long-term debt		
2.2% senior notes due March 2019	—	375
2.25% senior notes due August 2019	—	850
3.125% senior notes due March 2020	723	2,000
Floating rate notes due March 2020	277	1,000
2.8% senior notes due July 2020	2,750	2,750
3.35% senior notes due March 2021	2,038	3,000
Floating rate notes due March 2021	1,000	1,000
4.125% senior notes due May 2021	222	550
2.125% senior notes due June 2021	1,750	1,750
4.125% senior notes due June 2021	203	500
5.45% senior notes due June 2021	187	600
3-year tranche term loan due November 2021	—	3,000
3.5% senior notes due July 2022	1,500	1,500
2.75% senior notes due November 2022	1,000	1,000
2.75% senior notes due December 2022	1,250	1,250
4.75% senior notes due December 2022	399	399
3.7% senior notes due March 2023	6,000	6,000
2.8% senior notes due June 2023	1,300	1,300
4% senior notes due December 2023	1,250	1,250
2.625% senior notes due August 2024	1,000	—
3.375% senior notes due August 2024	650	650
3.5% senior notes due November 2024	750	750
5% senior notes due December 2024	299	299
4.1% senior notes due March 2025	5,000	5,000
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
3% senior notes due August 2026	750	—
6.25% senior notes due June 2027	372	372
4.3% senior notes due March 2028	9,000	9,000
3.25% senior notes due August 2029	1,750	—
4.875% senior notes due July 2035	652	652
6.625% senior notes due June 2036	771	771
6.75% senior notes due December 2037	533	533
4.78% senior notes due March 2038	5,000	5,000
6.125% senior notes due September 2039	447	447
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	500
4.125% senior notes due November 2042	500	500
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	375
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	1,000
5.05% senior notes due March 2048	8,000	8,000
Finance lease obligations	618	642
Other	1	19
Total debt principal	69,848	74,265
Debt premiums	267	302

Debt discounts and deferred financing costs	(1,061)	(1,138)
	69,054	73,429
Less:		
Short-term debt (commercial paper)	(1,070)	(720)
Current portion of long-term debt	(3,778)	(1,265)
Long-term debt	$ 64,206	$ 71,444

Long-term Borrowings

2019 Notes
On August 15, 2019, the Company issued $1.0 billion aggregate principal amount of 2.625% unsecured senior notes due August 15, 2024, $750 million aggregate principal amount of 3% unsecured senior notes due August 15, 2026 and $1.75 billion aggregate principal amount of 3.25% unsecured senior notes due August 15, 2029 (collectively, the "2019 Notes") for total proceeds of approximately $3.5 billion, net of discounts and underwriting fees. The net proceeds of the 2019 Notes were used to repay certain of the Company's outstanding debt.

Beginning in July 2019, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the 2019 Notes. In connection with the issuance of the 2019 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $25 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $18 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the 2019 Notes. See Note 9 "Other Comprehensive Income (Loss)" for additional information.

Early Extinguishment of Debt
In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna, $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

8. Shareholders' Equity

Share Repurchases

On November 2, 2016, the Company's Board of Directors (the "Board") authorized the 2016 share repurchase program ("2016 Repurchase Program") for up to $15.0 billion of the Company's common shares. The 2016 Repurchase Program permits the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time.

During the nine months ended September 30, 2019 and 2018, the Company did not repurchase any shares of its common stock. At September 30, 2019, the Company had remaining authorization to repurchase an aggregate of up to approximately $13.9 billion of its common shares under the 2016 Repurchase Program.

Dividends

The quarterly cash dividend declared by the Board was $0.50 per share in each of the three-month periods ended September 30, 2019 and 2018. Cash dividends declared year to date by the Board were $1.50 per share in each of the nine-month periods ended September 30, 2019 and 2018. CVS Health has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

9. Other Comprehensive Income (Loss)

Shareholders' equity included the following activity in accumulated other comprehensive income for the three and nine months ended September 30, 2019 and 2018:

	Three Months Ended September 30,		Nine Months Ended September 30,	
In millions	2019	2018	2019	2018
Net unrealized investment gains (losses):				
Beginning of period balance	$ 682	$ —	$ 97	$ —
Other comprehensive income before reclassifications *($214, $0, $933 and $0 pretax)*	192	—	799	—
Amounts reclassified from accumulated other comprehensive income *($(63), $0, $(93) and $0 pretax)* (1)	(56)	—	(78)	—
Other comprehensive income	136	—	721	—
End of period balance	818	—	818	—
Foreign currency translation adjustments:				
Beginning of period balance	(154)	(155)	(158)	(129)
Other comprehensive income (loss) before reclassifications	(1)	(8)	3	(34)
Amounts reclassified from accumulated other comprehensive loss (2)	154	—	154	—
Other comprehensive income (loss)	153	(8)	157	(34)
End of period balance	(1)	(163)	(1)	(163)
Net cash flow hedges:				
Beginning of period balance	305	321	312	(15)
Adoption of new accounting standard (3)	—	—	—	(3)
Other comprehensive income (loss) before reclassifications *($(25), $0, $(25) and $464 pretax)*	(18)	—	(18)	344
Amounts reclassified from accumulated other comprehensive income (loss) *($(7), $(5), $(16) and $(12) pretax)* (4)	(5)	(4)	(12)	(9)
Other comprehensive income (loss)	(23)	(4)	(30)	335
End of period balance	282	317	282	317
Pension and OPEB plans:				
Beginning of period balance	(149)	(25)	(149)	(21)
Adoption of new accounting standard (3)	—	—	—	(4)
End of period balance	(149)	(25)	(149)	(25)
Total beginning of period accumulated other comprehensive income (loss)	684	141	102	(165)
Adoption of new accounting standard (3)	—	—	—	(7)
Total other comprehensive income (loss)	266	(12)	848	301
Total end of period accumulated other comprehensive income	$ 950	$ 129	$ 950	$ 129

(1) Amounts reclassified from accumulated other comprehensive income for specifically identified debt securities are included in net investment income in the unaudited condensed consolidated statements of operations.

(2) Amounts reclassified from accumulated other comprehensive loss represent the elimination of the cumulative translation adjustment associated with the sale of Onofre, which was sold on July 1, 2019. The loss on the divestiture of Onofre is reflected in operating expenses in the unaudited condensed consolidated statements of operations.

(3) Reflects the adoption of ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income* during the nine months ended September 30, 2018.

(4) Amounts reclassified from accumulated other comprehensive income (loss) for specifically identified cash flow hedges are included in interest expense in the unaudited condensed consolidated statements of operations. The Company expects to reclassify approximately $15 million, net of tax, in net gains associated with its cash flow hedges into net income within the next 12 months.

10. Earnings (Loss) Per Share

Earnings (loss) per share is computed using the two-class method. For periods in which the Company reports net income, diluted earnings per share is determined by using the weighted average number of common and dilutive common equivalent shares outstanding during the period, unless the effect is antidilutive. Stock appreciation rights and options to purchase 18 million and 19 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the three and nine months ended September 30, 2019, respectively, because their exercise prices were greater than the average market price of the common shares and, therefore, the effect would be antidilutive. For the same reason, options to purchase 12 million and 14 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the three and nine months ended September 30, 2018, respectively. Due to the loss from continuing operations attributable to CVS Health in the nine months ended September 30, 2018, 2 million potentially dilutive common equivalent shares also were excluded from the calculation of diluted earnings per share, as the impact of these shares was antidilutive.

The following is a reconciliation of basic and diluted earnings (loss) per share from continuing operations for the respective periods:

	Three Months Ended September 30,		Nine Months Ended September 30,	
In millions, except per share amounts	**2019**	**2018**	**2019**	**2018**
Numerator for earnings (loss) per share calculation:				
Income (loss) from continuing operations	$ 1,529	$ 1,390	$ 4,887	$ (174)
Income from continuing operations allocated to participating securities	—	(1)	(3)	(3)
Loss from continuing operations attributable to noncontrolling interest	1	—	—	—
Income (loss) from continuing operations attributable to CVS Health	$ 1,530	$ 1,389	$ 4,884	$ (177)
Denominator for earnings (loss) per share calculation:				
Weighted average shares, basic	1,302	1,020	1,300	1,018
Effect of dilutive securities	3	2	3	—
Weighted average shares, diluted	1,305	1,022	1,303	1,018
Earnings (loss) per share from continuing operations:				
Basic	$ 1.17	$ 1.36	$ 3.76	$ (0.17)
Diluted	$ 1.17	$ 1.36	$ 3.75	$ (0.17)

11. Reinsurance

The Company utilizes reinsurance agreements primarily to reduce required capital and to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans to a subsidiary of WellCare Health Plans, Inc. ("WellCare"), effective December 31, 2018. In connection with that sale, subsidiaries of WellCare and Aetna entered into reinsurance agreements under which WellCare has ceded to Aetna 100% of the insurance risk related to the divested standalone Medicare Part D prescription drug plans for the 2019 PDP plan year.

In January 2019, the Company entered into two four-year reinsurance agreements with an unrelated reinsurer that allow it to reduce required capital and provide collateralized excess of loss reinsurance coverage on a portion of the Health Care Benefits segment's group Commercial Insured business.

12. Commitments and Contingencies

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of September 30, 2019, the Company guaranteed approximately 79 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the unaudited condensed consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies' usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. In June 2019, the Company and the Texas Attorney General commenced a civil jury trial in the *qui tam* action. Prior to the conclusion of that trial, the parties reached a settlement in principle on the remaining issues.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. In June 2019, the U.S. Court of Appeals for the Ninth Circuit reversed the District Court's grant of summary judgment and reversed the District Court's narrowing of the requested class. The *Corcoran* case is now proceeding to a trial on a class basis. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Circuit Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi, originally in the Chancery Court, but later transferred to the Circuit Court. The complaint alleged that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In June 2019, the Company's motion for judgment on the pleadings was granted in part and denied in part. Also in June 2019, the State of Mississippi's motion to dismiss the Company's counterclaim for declaratory relief was granted. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

Bewley, et al. v. *CVS Health Corporation*, et al. and *Prescott*, et al. v. *CVS Health Corporation*, et al. (both previously pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases alleged that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims were made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases were transferred to the U.S. District Court for the District of New Jersey on defendants' motions. In April 2019, the named plaintiffs in both the *Bewley* and *Prescott* cases voluntarily dismissed all of their claims without prejudice, ending both cases.

Klein, et al. v. *Prime Therapeutics*, et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation*. The Company is defending itself against these claims.

The Company has received subpoenas, CIDs, and other requests for documents and information from, and is being investigated by, Attorneys General of several states regarding its PBM practices, including pricing and rebates. In addition, the Company received an inquiry from the U.S. Senate Committee on Finance regarding insulin pricing. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. In addition, the Company has been named as a defendant in similar cases brought by certain state Attorneys General. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General and insurance and other regulators of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). In some instances, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served the Company with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Omnicare pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Omnicare pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the trial arbitrator awarded the claimant hospitals approximately $150 million. Aetna appealed the trial arbitrator's decision. On March 28, 2019, the appellate arbitrator reduced the award to approximately $86 million. The proceeding has ended. During the nine months ended September 30, 2019, the Company recorded the reduction in the required reserve amount for this proceeding as a measurement period adjustment to its Aetna Acquisition accounting and recorded a reduction to goodwill.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

The United States Centers for Medicare & Medicaid Services ("CMS") regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified

in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange-related or other audits by CMS, the OIG, the United States Department of Health and Human Services or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the United States Department of Justice (the "DOJ") in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. On September 4, 2019, the United States District Court for the District of Columbia (the "D.C. District Court") entered a final order that concluded the court approval process for the consent decree under the Antitrust Procedures and Penalties Act. The final order was issued without conditions. No further action is required by the D.C District Court, the DOJ or any other entity with regard to CVS Health's acquisition of Aetna.

Shareholder Matters

Between February and August 2019, six class action complaints were filed by putative plaintiffs against the Company and certain current and former officers and directors: *Anarkat v. CVS Health Corp., et al.,* Case No. 1:19-cv-00437 (U.S. District Court for the District of Rhode Island); *Labourers' Pension Fund of Central and Eastern Canada v. CVS Health Corp., et al.,* Case No. 651700/2019 (New York Supreme Court); *City of Warren Police and Fire Retirement Sys.v. CVS Health Corp., et. al.*, Case No. PC-2019-5658 (Rhode Island Superior Court); *Cambria Co. Employees Retirement Sys. v. CVS Health Corp., et al.*, Case No. 653223/2019 (New York Supreme Court); *Freundlich v. CVS Health Corp., et al.*, Case No. PC-2019-6685 (Rhode Island Superior Court); and *Waterford Twp. Police & Fire Retirement Sys. v. CVS Health Corp., et al.,* Case No. 19-cv-00434 (U.S. District Court for the District of Rhode Island). The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit, which allegedly injured investors who acquired CVS Health securities between February 9, 2016 and February 20, 2019. The *Freundlich* case also alleges that defendants misrepresented anticipated synergies of the Aetna Acquisition. The Company is defending itself against these claims.

Other Legal and Regulatory Proceedings

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, arising, for the most part, in the ordinary course of its businesses. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and

employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

13. Segment Reporting

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Effective for the first quarter of 2019, adjusted operating income is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. Segment financial information for the three and nine months ended September 30, 2018 has been retrospectively adjusted to conform with the current period presentation. See the reconciliation of consolidated operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

Effective for the first quarter of 2019, the Company realigned the composition of its segments to correspond with changes to its operating model and reflect how the CODM reviews information and manages the business. See Note 1 "Significant Accounting Policies" for further discussion. Segment financial information for the three and nine months ended September 30, 2018, has been retrospectively adjusted to reflect these changes as shown below:

	Three Months Ended September 30, 2018					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Revenues, as previously reported	$ 33,767	$ 20,856	$ —	$ 217	$ (7,350)	$ 47,490
Adjustments	97	—	641	—	(738)	—
Revenues, as adjusted	$ 33,864	$ 20,856	$ 641	$ 217	$ (8,088)	$ 47,490
Cost of products sold [1]	$ 31,587	$ 15,042	$ —	$ —	$ (7,127)	$ 39,502
Adjustments	651	—	—	—	(651)	—
Cost of products sold, as adjusted	$ 32,238	$ 15,042	$ —	$ —	$ (7,778)	$ 39,502
Benefit costs [1]	$ 439	$ —	$ —	$ —	$ —	$ 439
Adjustments	(439)	—	439	—	—	—
Benefit costs, as adjusted	$ —	$ —	$ 439	$ —	$ —	$ 439
Operating expenses, as previously reported	$ 392	$ 4,323	$ —	$ 287	$ (27)	$ 4,975
Adjustments	(41)	—	128	—	(87)	—
Operating expenses, as adjusted	$ 351	$ 4,323	$ 128	$ 287	$ (114)	$ 4,975
Operating income (loss), as previously reported	$ 1,349	$ 1,491	$ —	$ (70)	$ (196)	$ 2,574
Adjustments	(74)	—	74	—	—	—
Operating income (loss), as adjusted	1,275	1,491	74	(70)	(196)	2,574
Segment measure adjustments	87	131	1	(143)	—	76
Adjusted operating income (loss)	$ 1,362	$ 1,622	$ 75	$ (213)	$ (196)	$ 2,650

(1) The total of cost of products sold and benefit costs previously were reported as cost of revenues.

	Nine Months Ended September 30, 2018					
In millions	Pharmacy Services	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
Revenues, as previously reported	$ 99,238	$ 61,960	$ —	$ 475	$ (21,518)	$ 140,155
Adjustments	599	—	2,723	—	(3,322)	—
Revenues, as adjusted	$ 99,837	$ 61,960	$ 2,723	$ 475	$ (24,840)	$ 140,155
Cost of products sold [1]	$ 92,459	$ 44,318	$ —	$ —	$ (20,894)	$ 115,883
Adjustments	3,059	—	—	—	(3,059)	—
Cost of products sold, as adjusted	$ 95,518	$ 44,318	$ —	$ —	$ (23,953)	$ 115,883
Benefit costs [1]	$ 2,399	$ —	$ —	$ —	$ —	$ 2,399
Adjustments	(2,399)	—	2,399	—	—	—
Benefit costs, as adjusted	$ —	$ —	$ 2,399	$ —	$ —	$ 2,399
Operating expenses, as previously reported	$ 1,176	$ 12,831	$ —	$ 814	$ (66)	$ 14,755
Adjustments	(125)	—	388	—	(263)	—
Operating expenses, as adjusted	$ 1,051	$ 12,831	$ 388	$ 814	$ (329)	$ 14,755
Operating income (loss), as previously reported	$ 3,204	$ 890	$ —	$ (339)	$ (558)	$ 3,197
Adjustments	64	—	(64)	—	—	—
Operating income (loss), as adjusted	3,268	890	(64)	(339)	(558)	3,197
Segment measure adjustments	262	4,389	2	(308)	—	4,345
Adjusted operating income (loss)	$ 3,530	$ 5,279	$ (62)	$ (647)	$ (558)	$ 7,542

(1) The total of cost of products sold and benefit costs previously were reported as cost of revenues.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	Pharmacy Services [1]	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
Three Months Ended						
September 30, 2019						
Revenues from customers	$ 36,018	$ 21,466	$ 17,035	$ 35	$ (10,007)	$ 64,547
Net investment income	—	—	146	117	—	263
Total revenues	36,018	21,466	17,181	152	(10,007)	64,810
Adjusted operating income (loss)	1,439	1,516	1,423	(252)	(179)	3,947
September 30, 2018						
Revenues from customers	$ 33,864	$ 20,856	$ 637	$ —	$ (8,088)	$ 47,269
Net investment income	—	—	4	217	—	221
Total revenues	33,864	20,856	641	217	(8,088)	47,490
Adjusted operating income (loss)	1,362	1,622	75	(213)	(196)	2,650
Nine Months Ended						
September 30, 2019						
Revenues from customers	$ 104,418	$ 64,028	$ 51,996	$ 76	$ (31,436)	$ 189,082
Net investment income	—	—	458	347	—	805
Total revenues	104,418	64,028	52,454	423	(31,436)	189,887
Adjusted operating income (loss)	3,682	4,674	4,423	(685)	(521)	11,573
September 30, 2018						
Revenues from customers	$ 99,837	$ 61,960	$ 2,713	$ —	$ (24,840)	$ 139,670
Net investment income	—	—	10	475	—	485
Total revenues	99,837	61,960	2,723	475	(24,840)	140,155
Adjusted operating income (loss)	3,530	5,279	(62)	(647)	(558)	7,542

(1) Total revenues of the Pharmacy Services segment include approximately $2.7 billion of retail co-payments for each of the three-month periods ended September 30, 2019 and 2018, and $8.9 billion and $8.8 billion of retail co-payments for the nine months ended September 30, 2019 and 2018, respectively.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services segment, the Retail/LTC segment and/or the Health Care Benefits segment.

The following are reconciliations of consolidated operating income to adjusted operating income for the three and nine months ended September 30, 2019 and 2018:

	Three Months Ended September 30,		Nine Months Ended September 30,	
In millions	**2019**	**2018**	**2019**	**2018**
Operating income (GAAP measure)	$ 2,928	$ 2,574	$ 8,950	$ 3,197
Amortization of intangible assets [1]	607	215	1,822	639
Acquisition-related transaction and integration costs [2]	111	70	365	152
Store rationalization charges [3]	96	—	231	—
Loss on divestiture of subsidiary [4]	205	—	205	86
Goodwill impairment [5]	—	—	—	3,921
Interest income on financing for the Aetna Acquisition [6]	—	(209)	—	(453)
Adjusted operating income	$ 3,947	$ 2,650	$ 11,573	$ 7,542

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) During the three and nine months ended September 30, 2019 and 2018, acquisition-related transaction and integration costs relate to the Aetna Acquisition. During the nine months ended September 30, 2018, acquisition-related integration costs also relate to the acquisition of Omnicare, Inc. The acquisition-related transaction and integration costs are reflected in the Company's unaudited GAAP condensed consolidated statements of operations in operating expenses primarily within the Corporate/Other segment.

(3) During the three and nine months ended September 30, 2019, the store rationalization charges relate to the planned closure of 22 underperforming retail pharmacy stores in the first quarter of 2020. During the nine months ended September 30, 2019, the store rationalization charges also relate to the planned closure of 46 underperforming retail pharmacy stores in the second quarter of 2019. The store rationalization charges primarily relate to operating lease right-of-use asset impairment charges and are reflected in the Company's unaudited GAAP condensed consolidated statements of operations in operating expenses within the Retail/LTC segment.

(4) During the three and nine months ended September 30, 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in operating expenses in the Company's unaudited GAAP condensed consolidated statements of operations within the Retail/LTC segment. During the nine months ended September 30, 2018, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of the Company's RxCrossroads subsidiary for $725 million and is reflected in operating expenses in the Company's unaudited GAAP condensed consolidated statements of operations within the Retail/LTC segment.

(5) During the nine months ended September 30, 2018, the goodwill impairment charge relates to the LTC reporting unit within the Retail/LTC segment.

(6) During the three and nine months ended September 30, 2018, the Company recorded interest income of $209 million and $453 million, respectively, on the proceeds of its unsecured senior notes issued in March 2018 to partially fund the Aetna Acquisition. All amounts are for the periods prior to the close of the Aetna Acquisition, which occurred on November 28, 2018, and were recorded within the Corporate/Other segment.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Results of Review of Interim Financial Statements

We have reviewed the accompanying condensed consolidated balance sheet of CVS Health Corporation (the Company) as of September 30, 2019, the related condensed consolidated statements of operations and comprehensive income for the three-month and nine-month periods ended September 30, 2019 and 2018, the related condensed consolidated statements of shareholders' equity for the three-month periods ended March 31, 2019 and 2018, June 30, 2019 and 2018 and September 30, 2019 and 2018, the related condensed consolidated statements of cash flows for the nine-month periods ended September 30, 2019 and 2018, and the related notes (collectively referred to as the "condensed consolidated interim financial statements"). Based on our reviews, we are not aware of any material modifications that should be made to the condensed consolidated interim financial statements for them to be in conformity with U.S. generally accepted accounting principles.

We have previously audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheet of the Company as of December 31, 2018, the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for the year then ended, and the related notes (not presented herein); and in our report dated February 28, 2019, we expressed an unqualified audit opinion on those consolidated financial statements. In our opinion, the information set forth in the accompanying condensed consolidated balance sheet as of December 31, 2018, is fairly stated, in all material respects, in relation to the consolidated balance sheet from which it has been derived.

Adoption of ASU 2016-02

As discussed in Note 1 to the condensed consolidated interim financial statements, the Company changed its method of accounting for leases in 2019 due to the adoption of ASU 2016-02, *Leases*.

Basis for Review Results

These financial statements are the responsibility of the Company's management. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the SEC and the PCAOB. We conducted our review in accordance with the standards of the PCAOB. A review of interim financial statements consists principally of applying analytical procedures and making inquiries of persons responsible for financial and accounting matters. It is substantially less in scope than an audit conducted in accordance with the standards of the PCAOB, the objective of which is the expression of an opinion regarding the financial statements taken as a whole. Accordingly, we do not express such an opinion.

/s/ Ernst & Young LLP

Boston, Massachusetts
November 6, 2019

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A")

Overview of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has approximately 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 102 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year and expanding specialty pharmacy services. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings and a leading standalone Medicare Part D prescription drug plan ("PDP"). The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment.

Effective for the first quarter of 2019, the Company realigned the composition of its segments to correspond with changes to its operating model and reflect how its Chief Operating Decision Maker (the "CODM") reviews information and manages the business. As a result of this realignment, the Company's SilverScript® PDP moved from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company moved Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment. Segment financial information for the three and nine months ended September 30, 2018, has been retrospectively adjusted to reflect these changes.

The Company has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below.

Overview of the Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, PDPs, Medicaid managed care plans, plans offered on public health insurance exchanges and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the nine months ended September 30, 2019, the Company's PBM filled or managed 1.5 billion prescriptions on a 30-day equivalent basis.

Overview of the Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. As of September 30, 2019, the Retail/LTC segment operated approximately 9,900 retail locations, approximately 1,100 MinuteClinic® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the nine months ended September 30, 2019, the Retail/LTC segment filled 1.0 billion prescriptions on a 30-day equivalent basis.

Overview of the Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of September 30, 2019. The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make more informed decisions about their health care. The Health

Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental and behavioral health plans, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk for medical and dental care costs) as "ASC."

Overview of the Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments and acquisition-related transaction and integration costs; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Operating Results

The following discussion explains the material changes in the Company's operating results for the three and nine months ended September 30, 2019 and 2018, and the significant developments affecting the Company's financial condition since December 31, 2018. We strongly recommend that you read our audited consolidated financial statements and notes thereto and Management's Discussion and Analysis of Financial Condition and Results of Operations for the year ended December 31, 2018, which were revised to reflect the Company's segment realignment and are included in Exhibit 99.2 to the Company's Current Report on Form 8-K filed with the United States Securities and Exchange Commission (the "SEC") on August 8, 2019 (the "August 2019 8-K").

Summary of Consolidated Financial Results

	Three Months Ended September 30,		Nine Months Ended September 30,		Change			
					Three Months Ended September 30, 2019 vs 2018		Nine Months Ended September 30, 2019 vs 2018	
In millions	2019	2018	2019	2018	$	%	$	%
Revenues:								
Products	$ 47,149	$ 46,334	$ 136,023	$ 136,035	$ 815	1.8 %	$ (12)	— %
Premiums	15,539	627	47,612	2,684	14,912	2,378.3 %	44,928	1,673.9 %
Services	1,859	308	5,447	951	1,551	503.6 %	4,496	472.8 %
Net investment income	263	221	805	485	42	19.0 %	320	66.0 %
Total revenues	64,810	47,490	189,887	140,155	17,320	36.5 %	49,732	35.5 %
Operating costs:								
Cost of products sold	40,437	39,502	116,654	115,883	935	2.4 %	771	0.7 %
Benefit costs	12,850	439	39,396	2,399	12,411	2,827.1 %	36,997	1,542.2 %
Goodwill impairment	—	—	—	3,921	—	— %	(3,921)	(100.0)%
Operating expenses	8,595	4,975	24,887	14,755	3,620	72.8 %	10,132	68.7 %
Total operating costs	61,882	44,916	180,937	136,958	16,966	37.8 %	43,979	32.1 %
Operating income	2,928	2,574	8,950	3,197	354	13.8 %	5,753	179.9 %
Interest expense	747	674	2,301	1,886	73	10.8 %	415	22.0 %
Loss on early extinguishment of debt	79	—	79	—	79	100.0 %	79	100.0 %
Other expense (income)	(31)	1	(93)	7	(32)	(3,200.0)%	(100)	(1,428.6)%
Income before income tax provision	2,133	1,899	6,663	1,304	234	12.3 %	5,359	411.0 %
Income tax provision	604	509	1,776	1,478	95	18.7 %	298	20.2 %
Income (loss) from continuing operations	1,529	1,390	4,887	(174)	139	10.0 %	5,061	2,908.6 %
Loss from discontinued operations, net of tax	—	—	—	(1)	—	— %	1	(100.0)%
Net income (loss)	1,529	1,390	4,887	(175)	139	10.0 %	5,062	2,892.6 %
Net loss attributable to noncontrolling interests	1	—	—	—	1	100.0 %	—	(100.0)%
Net income (loss) attributable to CVS Health	$ 1,530	$ 1,390	$ 4,887	$ (175)	$ 140	10.1 %	$ 5,062	2,892.6 %

Commentary - Three Months Ended September 30, 2019 vs. 2018

Revenues

- Total revenues increased $17.3 billion, or 36.5%, in the three months ended September 30, 2019 compared to the prior year. The increase in total revenues was primarily driven by the impact of the Aetna Acquisition (primarily reflected in the Health Care Benefits segment) which occurred in November 2018, a 6.4% increase in Pharmacy Services segment revenue, and a 2.9% increase in Retail/LTC segment revenue.
- Please see "Segment Analysis" later in this report for additional information about the revenues of the Company's segments.

Operating expenses

- Operating expenses increased $3.6 billion, or 72.8%, in the three months ended September 30, 2019 compared to the prior year. Operating expenses as a percentage of total revenues were 13.3% in the three months ended September 30, 2019, an increase of 280 basis points compared to the prior year. The increase in operating expenses was primarily driven by the impact of the Aetna Acquisition (including intangible asset amortization) and higher operating expenses in the Retail/LTC segment, including a $205 million pre-tax loss on the sale of the Company's Brazilian subsidiary, Drogaria Onofre Ltda. ("Onofre"), and a $96 million store rationalization charge, each recorded in the three months ended September 30, 2019.
- Please see "Segment Analysis" later in this report for additional information about the operating expenses of the Company's segments.

Operating income

- Operating income increased $354 million, or 13.8%, in the three months ended September 30, 2019 compared to the prior year. The increase was primarily due to the impact of the Aetna Acquisition as well as increased claims volume and improved purchasing economics in the Pharmacy Services segment. These increases were partially offset by:
  - Continued reimbursement pressure in the Retail/LTC segment;
  - Continued price compression in the Pharmacy Services segment;
  - An increase in intangible asset amortization primarily related to the Aetna Acquisition;
  - Higher operating expenses in the Retail/LTC segment, including the $205 million pre-tax loss on the sale of Onofre and the $96 million store rationalization charge, each recorded in the three months ended September 30, 2019; and
  - The absence of $209 million in interest income on the proceeds from the financing for the Aetna Acquisition recorded in the three months ended September 30, 2018.
- Please see "Segment Analysis" later in this report for additional information about the operating income of the Company's segments.

Interest expense

- Interest expense increased $73 million in the three months ended September 30, 2019 compared to the prior year, primarily due to the assumption of Aetna's debt as of the Aetna Acquisition Date. See "Liquidity and Capital Resources" later in this report for additional information.

Loss on early extinguishment of debt

- During the three months ended September 30, 2019, the loss on early extinguishment of debt relates to the Company's repayment of $4.0 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in August 2019, which resulted in a loss on early extinguishment of debt of $79 million. See Note 7 "Borrowings" to the unaudited condensed consolidated financial statements for additional information.

Income tax provision

- The Company's effective income tax rate was 28.3% in the three months ended September 30, 2019 compared to 26.8% for the prior year. The increase in the effective income tax rate was primarily due to the impact of the sale of Onofre in the three months ended September 30, 2019.

Commentary - Nine Months Ended September 30, 2019 vs. 2018

Revenues

- Total revenues increased $49.7 billion, or 35.5%, in the nine months ended September 30, 2019 compared to the prior year. The increase in total revenues was primarily driven by the impact of the Aetna Acquisition (primarily reflected in the Health Care Benefits segment) which occurred in November 2018, a 4.6% increase in Pharmacy Services segment revenue, and a 3.3% increase in Retail/LTC segment revenue.

- Please see "Segment Analysis" later in this report for additional information about the revenues of the Company's segments.

Operating expenses

- Operating expenses increased $10.1 billion, or 68.7%, in the nine months ended September 30, 2019 compared to the prior year. Operating expenses as a percentage of total revenues were 13.1% in the nine months ended September 30, 2019, an increase of 260 basis points compared to the prior year. The increase in operating expenses is primarily due to the impact of the Aetna Acquisition (including intangible asset amortization), higher operating expenses in the Retail/LTC segment, including $231 million of store rationalization charges and the $205 million pre-tax loss on the sale of Onofre recorded in the nine months ended September 30, 2019, and an increase in acquisition-related integration costs.
- Please see "Segment Analysis" later in this report for additional information about the operating expenses of the Company's segments.

Operating income

- Operating income increased $5.8 billion in the nine months ended September 30, 2019 compared to the prior year. The increase was primarily due to the absence of the $3.9 billion pre-tax goodwill impairment charge related to the LTC reporting unit within the Retail/LTC segment recorded in the nine months ended September 30, 2018 and the impact of the Aetna Acquisition. The increase was partially offset by reimbursement pressure and higher operating expenses in the Retail/LTC segment and an increase in acquisition-related integration costs.
- Please see "Segment Analysis" later in this report for additional information about the operating income of the Company's segments.

Interest expense

- Interest expense increased $415 million in the nine months ended September 30, 2019 compared to the prior year, primarily due to the financing activity associated with the Aetna Acquisition and the assumption of Aetna's debt as of the Aetna Acquisition Date. See "Liquidity and Capital Resources" later in this report for additional information.

Loss on early extinguishment of debt

- During the nine months ended September 30, 2019, the loss on early extinguishment of debt relates to the Company's repayment of $4.0 billion of its outstanding senior notes pursuant to its tender offers for such senior notes in August 2019, which resulted in a loss on early extinguishment of debt of $79 million. See Note 7 "Borrowings" to the unaudited condensed consolidated financial statements for additional information.

Income tax provision

- The Company's effective income tax rate was 26.7% in the nine months ended September 30, 2019 compared to 113.3% for the prior year. The decrease in the effective income tax rate was primarily due to the $3.9 billion goodwill impairment charge recognized in the nine months ended September 30, 2018, which was not deductible for income tax purposes.

Outlook

With respect to the fourth quarter of 2019, the Company believes you should consider the following important information:

- The Health Care Benefits segment's operating income generally is lowest in the fourth quarter of the year primarily due to (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses which are generally the highest during the fourth quarter due to increased spending to support readiness for the start of the 2020 plan year in the Medicare business and marketing associated with Medicare annual enrollment.
- Due to the timing of the closing of the Aetna Acquisition, the fourth quarter of 2018 does not include the full impact of common share dilution and interest expense resulting from the Aetna Acquisition. These differences affect year-over-year comparability of, among other things, earnings per share.

With respect to 2020, the Company believes you should consider the following important information:

- The Company believes that it is on track to achieve its 2020 target of approximately $800 million of synergies from the Aetna Acquisition.
- The ACA imposes a significant industry-wide fee known as the Health Insurer Fee (the "HIF"). The HIF is non-deductible for federal income tax purposes and is allocated to insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to the amount of health insurance premium for all U.S. health risk for certain lines of business during the preceding calendar year. The HIF was suspended for 2017, $14.3 billion for 2018 and suspended for 2019. As currently enacted, the HIF will be $15.5 billion for 2020 and increase in 2021 and annually thereafter. In October 2018, Aetna and CVS paid an aggregate of approximately $1.0 billion representing their aggregate share of the 2018 HIF. The Company's 2019 financial results do not reflect any expense for the HIF since the HIF was suspended for 2019, and the Company expects its 2020 effective income tax rate to increase compared to 2019 due to the non-deductibility of the 2020 HIF. While the Company seeks to price its products to cover the increased selling, general and administrative and income tax expenses associated with the HIF, it may be particularly challenging for the Company to include all of its portion of the 2020 HIF in its premium rates beginning with 2019 medical customer renewals that have member months in 2020 because of the temporary suspension of the HIF for 2019.
- Changes to the Company's business environment may continue for the next several years as elected and other government officials at the national and state levels continue to propose and enact significant modifications to public policy and existing laws and regulations that govern the Company's businesses.

The Company's current expectations described above are forward-looking statements. Please see "Cautionary Statement Concerning Forward-Looking Statements" in this report for information regarding important factors that may cause the Company's actual results to differ from those currently projected and/or otherwise materially affect the Company.

Segment Analysis

The following discussion of segment operating results is presented based on the Company's reportable segments in accordance with the accounting guidance for segment reporting and is consistent with our segment disclosure in Note 13 "Segment Reporting" to the unaudited condensed consolidated financial statements.

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Effective for the first quarter of 2019, adjusted operating income is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. Segment financial information for the three and nine months ended September 30, 2018 has been retrospectively adjusted to conform with the current period presentation. See the reconciliations of operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

Effective for the first quarter of 2019, the Company realigned the composition of its segments to correspond with changes to its operating model and reflect how the CODM reviews information and manages the business. See Note 1 "Significant Accounting Policies" to the unaudited condensed consolidated financial statements for further discussion. Segment financial information for the three and nine months ended September 30, 2018, has been retrospectively adjusted to reflect these changes as shown in Note 13 "Segment Reporting" to the unaudited condensed consolidated financial statements.

The following is a reconciliation of financial measures of the Company's segments to the consolidated totals:

In millions	Pharmacy Services [1]	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
Three Months Ended						
September 30, 2019						
Total revenues	$ 36,018	$ 21,466	$ 17,181	$ 152	$ (10,007)	$ 64,810
Adjusted operating income (loss)	1,439	1,516	1,423	(252)	(179)	3,947
September 30, 2018						
Total revenues	33,864	20,856	641	217	(8,088)	47,490
Adjusted operating income (loss)	1,362	1,622	75	(213)	(196)	2,650
Nine Months Ended						
September 30, 2019						
Total revenues	$ 104,418	$ 64,028	$ 52,454	$ 423	$ (31,436)	$ 189,887
Adjusted operating income (loss)	3,682	4,674	4,423	(685)	(521)	11,573
September 30, 2018						
Total revenues	99,837	61,960	2,723	475	(24,840)	140,155
Adjusted operating income (loss)	3,530	5,279	(62)	(647)	(558)	7,542

(1) Total revenues of the Pharmacy Services segment include approximately $2.7 billion of retail co-payments for each of the three-month periods ended September 30, 2019 and 2018, and $8.9 billion and $8.8 billion of retail co-payments for the nine months ended September 30, 2019 and 2018, respectively.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services segment, the Retail/LTC segment and/or the Health Care Benefits segment.

The following are reconciliations of operating income to adjusted operating income for the three and nine months ended September 30, 2019 and 2018:

	Three Months Ended September 30, 2019					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 1,340	$ 1,095	$ 1,036	$ (364)	$ (179)	$ 2,928
Non-GAAP adjustments:						
Amortization of intangible assets [1]	99	120	387	1	—	607
Acquisition-related integration costs [2]	—	—	—	111	—	111
Store rationalization charge [3]	—	96	—	—	—	96
Loss on divestiture of subsidiary [4]	—	205	—	—	—	205
Adjusted operating income (loss)	$ 1,439	$ 1,516	$ 1,423	$ (252)	$ (179)	$ 3,947

	Three Months Ended September 30, 2018					
In millions	**Pharmacy Services**	**Retail/ LTC**	**Health Care Benefits**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Operating income (loss) (GAAP measure)	$ 1,275	$ 1,491	$ 74	$ (70)	$ (196)	$ 2,574
Non-GAAP adjustments:						
Amortization of intangible assets [1]	87	127	1	—	—	215
Acquisition-related transaction and integration costs [2]	—	4	—	66	—	70
Interest income on financing for the Aetna Acquisition [5]	—	—	—	(209)	—	(209)
Adjusted operating income (loss)	$ 1,362	$ 1,622	$ 75	$ (213)	$ (196)	$ 2,650

In millions	Nine Months Ended September 30, 2019					
	Pharmacy Services	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
Operating income (loss) (GAAP measure)	$ 3,387	$ 3,884	$ 3,253	$ (1,053)	$ (521)	$ 8,950
Non-GAAP adjustments:						
Amortization of intangible assets (1)	295	354	1,170	3	—	1,822
Acquisition-related integration costs (2)	—	—	—	365	—	365
Store rationalization charges (3)	—	231	—	—	—	231
Loss on divestiture of subsidiary (4)	—	205	—	—	—	205
Adjusted operating income (loss)	$ 3,682	$ 4,674	$ 4,423	$ (685)	$ (521)	$ 11,573

In millions	Nine Months Ended September 30, 2018					
	Pharmacy Services	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
Operating income (loss) (GAAP measure)	$ 3,268	$ 890	$ (64)	$ (339)	$ (558)	$ 3,197
Non-GAAP adjustments:						
Amortization of intangible assets (1)	262	375	2	—	—	639
Acquisition-related transaction and integration costs (2)	—	7	—	145	—	152
Loss on divestiture of subsidiary (4)	—	86	—	—	—	86
Goodwill impairment (6)	—	3,921	—	—	—	3,921
Interest income on financing for the Aetna Acquisition (5)	—	—	—	(453)	—	(453)
Adjusted operating income (loss)	$ 3,530	$ 5,279	$ (62)	$ (647)	$ (558)	$ 7,542

(1) The Company's acquisition activities have resulted in the recognition of intangible assets as required under the acquisition method of accounting which consist primarily of trademarks, customer contracts/relationships, covenants not to compete, technology, provider networks and value of business acquired. Definite-lived intangible assets are amortized over their estimated useful lives and are tested for impairment when events indicate that the carrying value may not be recoverable. The amortization of intangible assets is reflected in the Company's statements of operations in operating expenses within each segment. Although intangible assets contribute to the Company's revenue generation, the amortization of intangible assets does not directly relate to the underwriting of the Company's insurance products, the services performed for the Company's customers or the sale of the Company's products or services. Additionally, intangible asset amortization expense typically fluctuates based on the size and timing of the Company's acquisition activity. Accordingly, the Company believes excluding the amortization of intangible assets enhances the Company's and investors' ability to compare the Company's past financial performance with its current performance and to analyze underlying business performance and trends. Intangible asset amortization excluded from the related non-GAAP financial measure represents the entire amount recorded within the Company's GAAP financial statements and the revenue generated by the associated intangible assets has not been excluded from the related non-GAAP financial measure. Intangible asset amortization is excluded from the related non-GAAP financial measure because the amortization, unlike the related revenue, is not affected by operations of any particular period unless an intangible asset becomes impaired or the estimated useful life of an intangible asset is revised.

(2) During the three and nine months ended September 30, 2019 and 2018, acquisition-related transaction and integration costs relate to the Aetna Acquisition. During the nine months ended September 30, 2018, acquisition-related integration costs also relate to the acquisition of Omnicare, Inc ("Omnicare"). The acquisition-related transaction and integration costs are reflected in the Company's unaudited GAAP condensed consolidated statements of operations in operating expenses primarily within the Corporate/Other segment.

(3) During the three and nine months ended September 30, 2019, the store rationalization charges relate to the planned closure of 22 underperforming retail pharmacy stores in the first quarter of 2020. During the nine months ended September 30, 2019, the store rationalization charges also relate to the planned closure of 46 underperforming retail pharmacy stores in the second quarter of 2019. The store rationalization charges primarily relate to operating lease right-of-use asset impairment charges and are reflected in the Company's unaudited GAAP condensed consolidated statements of operations in operating expenses within the Retail/LTC segment.

(4) During the three and nine months ended September 30, 2019, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of Onofre, which occurred on July 1, 2019. The loss on divestiture primarily relates to the elimination of the cumulative translation adjustment from accumulated other comprehensive income and is reflected in operating expenses in the Company's unaudited GAAP condensed consolidated statements of operations within the Retail/LTC segment. During the nine months ended September 30, 2018, the loss on divestiture of subsidiary represents the pre-tax loss on the sale of the Company's RxCrossroads subsidiary for $725 million and is reflected in operating expenses in the Company's unaudited GAAP condensed consolidated statements of operations within the Retail/LTC segment.

(5) During the three and nine months ended September 30, 2018, the Company recorded interest income of $209 million and $453 million, respectively, on the proceeds of its unsecured senior notes issued in March 2018 to partially fund the Aetna Acquisition (the "2018 Notes"). All amounts are for the periods prior to the close of the Aetna Acquisition, which occurred on November 28, 2018, and were recorded within the Corporate/Other segment.

(6) During the nine months ended September 30, 2018, the goodwill impairment charge relates to the LTC reporting unit within the Retail/LTC segment.

Pharmacy Services Segment

The following table summarizes the Pharmacy Services segment's performance for the respective periods:

	Three Months Ended September 30,		Nine Months Ended September 30,		Change			
					Three Months Ended September 30, 2019 vs 2018		Nine Months Ended September 30, 2019 vs 2018	
In millions, except percentages	2019	2018	2019	2018	$	%	$	%
Revenues:								
Products	$ 35,883	$ 33,746	$ 104,056	$ 99,493	$ 2,137	6.3%	$ 4,563	4.6%
Services	135	118	362	344	17	14.4%	18	5.2%
Total revenues	36,018	33,864	104,418	99,837	2,154	6.4%	4,581	4.6%
Cost of products sold	34,300	32,238	99,918	95,518	2,062	6.4%	4,400	4.6%
Operating expenses	378	351	1,113	1,051	27	7.7%	62	5.9%
Operating expenses as a % of total revenues	1.0%	1.0%	1.1%	1.1%				
Operating income	$ 1,340	$ 1,275	$ 3,387	$ 3,268	$ 65	5.1%	$ 119	3.6%
Operating income as a % of total revenues	3.7%	3.8%	3.2%	3.3%				
Adjusted operating income (1)	$ 1,439	$ 1,362	$ 3,682	$ 3,530	$ 77	5.7%	$ 152	4.3%
Adjusted operating income as a % of total revenues	4.0%	4.0%	3.5%	3.5%				
Revenues (by distribution channel):								
Pharmacy network (2)	$ 22,469	$ 21,921	$ 66,071	$ 64,625	$ 548	2.5%	$ 1,446	2.2%
Mail choice (3)	13,403	11,812	37,912	34,807	1,591	13.5%	3,105	8.9%
Other	146	131	435	405	15	11.5%	30	7.4%
Pharmacy claims processed: (4)								
Total	509.5	466.3	1,480.3	1,405.2	43.2	9.3%	75.1	5.3%
Pharmacy network (2)	430.2	394.5	1,250.0	1,192.2	35.7	9.0%	57.8	4.8%
Mail choice (3)	79.3	71.8	230.3	213.0	7.5	10.4%	17.3	8.1%
Generic dispensing rate: (4)								
Total	88.1%	87.2%	88.3%	87.5%				
Pharmacy network (2)	88.7%	87.8%	88.9%	88.1%				
Mail choice (3)	85.3%	83.9%	85.1%	84.0%				
Mail choice penetration rate (3) (4)	15.6%	15.4%	15.6%	15.2%				

(1) See "Segment Analysis" above in this report for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Pharmacy Services segment.

(2) Pharmacy network revenues, pharmacy claims processed and generic dispensing rate do not include Maintenance Choice® activity, which is included within the mail choice category. Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and long-term care pharmacies, but excluding Maintenance Choice activity. Maintenance Choice permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS pharmacy retail store for the same price as mail order.

(3) Mail choice is defined as claims filled at a Pharmacy Services mail order facility, which includes specialty mail claims inclusive of Specialty Connect® claims picked up at retail, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program.

(4) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.

Commentary - Three Months Ended September 30, 2019 vs. 2018

Revenues

- Total revenues increased $2.2 billion, or 6.4%, to $36.0 billion for the three months ended September 30, 2019 compared to the prior year. The increase was primarily due to brand name drug price inflation as well as increased total pharmacy claims volume, partially offset by continued price compression and an increased generic dispensing rate.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 10.4% to 79.3 million claims in the three months ended September 30, 2019 compared to 71.8 million claims in the prior year. The increase in mail choice claims was primarily driven by the continued adoption of Maintenance Choice offerings.
  - During the three months ended September 30, 2019, the average revenue per mail choice claim, on a 30-day equivalent basis, increased by 2.7% compared to the prior year primarily due to growth in specialty pharmacy claims processed.
  - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 9.0% to 430.2 million claims in the three months ended September 30, 2019, compared to 394.5 million claims in the prior year. The increase in the pharmacy network claim volume was primarily due to net new business.
  - During the three months ended September 30, 2019, the average revenue per pharmacy network claim processed, on a 30-day equivalent basis, decreased 5.9% compared to the prior year as a result of continued price compression.
  - The Company's total generic dispensing rate increased to 88.1% in the three months ended September 30, 2019 compared to 87.2% in the prior year. The continued increase in the Company's generic dispensing rate was primarily due to the impact of new generic drug introductions and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate. The Company believes its generic dispensing rate will continue to increase in future periods, albeit at a slower pace. This increase will be affected by, among other things, the number of new brand and generic drug introductions and the Company's success at encouraging plan members to utilize generic drugs when they are available and clinically appropriate.

Operating expenses

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses; depreciation and amortization related to selling, general and administrative activities; and expenses related to specialty retail pharmacies, which include store and administrative payroll, employee benefits and occupancy costs.
- Operating expenses increased $27 million, or 7.7%, in the three months ended September 30, 2019 compared to the prior year. The increase in operating expenses was primarily due to growth in the business, including operating expenses associated with Aetna's mail order and specialty pharmacy operations (including intangible asset amortization) in the three months ended September 30, 2019.
- Operating expenses as a percentage of total revenues remained consistent at 1.0% in each of the three-month periods ended September 30, 2019 and 2018.

Operating income and adjusted operating income

- Operating income increased $65 million, or 5.1%, and adjusted operating income increased $77 million, or 5.7%, in the three months ended September 30, 2019 compared to the prior year. The increase in both operating income and adjusted operating income was primarily driven by increased claims volume, the addition of Aetna's mail order and specialty pharmacy operations and improved purchasing economics, partially offset by continued price compression. The increase in operating income also was partially offset by increased intangible asset amortization related to Aetna's mail order and specialty pharmacy operations.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates and/or discounts the Company receives from manufacturers, wholesalers and retail pharmacies continue to have an impact on operating income. In particular, competitive pressures in the PBM industry have caused the Company and other PBMs to continue to share with clients a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, marketplace dynamics and regulatory changes have limited the Company's ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and the Company expects these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Commentary - Nine Months Ended September 30, 2019 vs. 2018

Revenues

- Total revenues increased $4.6 billion, or 4.6%, to $104.4 billion for the nine months ended September 30, 2019 compared to the prior year. The increase was primarily due to brand name drug price inflation as well as increased total pharmacy claims volume, partially offset by continued price compression and an increased generic dispensing rate.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 8.1% to 230.3 million claims in the nine months ended September 30, 2019 compared to 213.0 million claims in the prior year. The increase in mail choice claims was primarily driven by the continued adoption of Maintenance Choice offerings.
  - During the nine months ended September 30, 2019, the average revenue per mail choice claim, on a 30-day equivalent basis, increased by 0.7% compared to the prior year primarily due to growth in specialty pharmacy claims processed.
  - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 4.8% to 1.3 billion claims in the nine months ended September 30, 2019, compared to 1.2 billion claims in the prior year. The increase in the pharmacy network claim volume was primarily due to net new business.
  - During the nine months ended September 30, 2019, the average revenue per pharmacy network claim processed, on a 30-day equivalent basis, decreased 2.5% compared to the prior year as a result of continued price compression.
  - The Company's total generic dispensing rate increased to 88.3% in the nine months ended September 30, 2019 compared to 87.5% in the prior year. The continued increase in the Company's generic dispensing rate was primarily due to the impact of new generic drug introductions and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate.

Operating expenses

- Operating expenses increased $62 million, or 5.9%, in the nine months ended September 30, 2019 compared to the prior year. The increase in operating expenses was primarily due to growth in the business, including operating expenses associated with Aetna's mail order and specialty pharmacy operations (including intangible asset amortization) and investments related to the Company's agreement with Anthem, Inc. during the nine months ended September 30, 2019.
- Operating expenses as a percentage of total revenues remained consistent at 1.1% in each of the nine-month periods ended September 30, 2019 and 2018.

Operating income and adjusted operating income

- Operating income increased $119 million, or 3.6%, and adjusted operating income increased $152 million, or 4.3%, in the nine months ended September 30, 2019 compared to the prior year. The increase in both operating income and adjusted operating income was primarily driven by increased claims volume, the addition of Aetna's mail order and specialty pharmacy operations and improved purchasing economics, partially offset by continued price compression. The increase in operating income also was partially offset by increased intangible asset amortization related to Aetna's mail order and specialty pharmacy operations.

Retail/LTC Segment

The following table summarizes the Retail/LTC segment's performance for the respective periods:

	Three Months Ended September 30,		Nine Months Ended September 30,		Change			
					Three Months Ended September 30, 2019 vs 2018		Nine Months Ended September 30, 2019 vs 2018	
In millions, except percentages	2019	2018	2019	2018	$	%	$	%
Revenues:								
Products	$ 21,273	$ 20,676	$ 63,403	$ 61,382	$ 597	2.9 %	$ 2,021	3.3 %
Services	193	180	625	578	13	7.2 %	47	8.1 %
Total revenues	21,466	20,856	64,028	61,960	610	2.9 %	2,068	3.3 %
Cost of products sold	15,656	15,042	46,504	44,318	614	4.1 %	2,186	4.9 %
Goodwill impairment	—	—	—	3,921	—	— %	(3,921)	(100.0)%
Operating expenses	4,715	4,323	13,640	12,831	392	9.1 %	809	6.3 %
Operating expenses as a % of total revenues	22.0%	20.7%	21.3%	20.7%				
Operating income	$ 1,095	$ 1,491	$ 3,884	$ 890	$ (396)	(26.6)%	$ 2,994	336.4 %
Operating income as a % of total revenues	5.1%	7.1%	6.1%	1.4%				
Adjusted operating income [1]	$ 1,516	$ 1,622	$ 4,674	$ 5,279	$ (106)	(6.5)%	$ (605)	(11.5)%
Adjusted operating income as a % of total revenues	7.1%	7.8%	7.3%	8.5%				
Revenues (by major goods/service lines):								
Pharmacy	$ 16,687	$ 16,123	$ 49,197	$ 47,428	$ 564	3.5 %	$ 1,769	3.7 %
Front Store	4,614	4,557	14,288	13,990	57	1.3 %	298	2.1 %
Other	165	176	543	542	(11)	(6.3)%	1	0.2 %
Prescriptions filled [2]	352.3	331.2	1,048.2	989.7	21.1	6.4 %	58.5	5.9 %
Revenues increase:								
Total	2.9%	6.4%	3.3%	5.9%				
Pharmacy	3.5%	8.4%	3.7%	8.0%				
Front Store	1.3%	2.0%	2.1%	1.5%				
Total prescription volume increase [2]	6.4%	8.9%	5.9%	8.9%				
Same store sales increase: [3]								
Total	3.6%	6.7%	3.9%	6.2%				
Pharmacy	4.5%	8.7%	4.7%	8.1%				
Front Store	0.6%	0.8%	1.3%	0.5%				
Prescription volume [2]	7.8%	9.2%	7.3%	9.1%				
Generic dispensing rate [2]	88.2%	87.3%	88.7%	87.8%				

(1) See "Segment Analysis" above in this report for a reconciliation of operating income (GAAP measure) to adjusted operating income for the Retail/LTC segment.
(2) Includes an adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.
(3) Same store sales and prescription volume exclude revenues from MinuteClinic, and revenue and prescriptions from stores in Brazil and LTC operations.

Commentary - Three Months Ended September 30, 2019 vs. 2018

Revenues

- Total revenues increased $610 million, or 2.9%, to $21.5 billion in the three months ended September 30, 2019 compared to the prior year. The increase was primarily driven by increased prescription volume and brand name drug price inflation, partially offset by continued reimbursement pressure and an increased generic dispensing rate.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
  - Front store same store sales increased 0.6% in the three months ended September 30, 2019 compared to the prior year. The increase in front store sales in 2019 was primarily driven by increases in health and beauty product sales, which benefited from continued strength in cough and cold products.
  - Pharmacy same store sales increased 4.5% in the three months ended September 30, 2019 compared to the prior year. The increase was driven by the 7.8% increase in pharmacy same store prescription volumes on a 30-day equivalent basis driven primarily by continued adoption of patient care programs.
  - Pharmacy revenue continues to be adversely affected by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 88.2% in the three months ended September 30, 2019 compared to 87.3% in the prior year. Pharmacy revenue growth also has been negatively affected by continued reimbursement pressure.
  - Pharmacy revenue growth also has been adversely affected by industry challenges in the LTC business, such as continuing lower occupancy rates at skilled nursing facilities, as well as the deteriorating financial health of many skilled nursing facilities.
  - Pharmacy revenue in 2019 continued to benefit from the Company's ability to attract and retain managed care customers and the increased use of pharmaceuticals by an aging population as the first line of defense for health care.

Operating expenses

- Operating expenses in the Retail/LTC segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.
- Operating expenses increased $392 million, or 9.1%, in the three months ended September 30, 2019 compared to the prior year, primarily due to the following:
  - The $205 million pre-tax loss on the sale of Onofre, which occurred on July 1, 2019;
  - The $96 million store rationalization charge recorded in the three months ended September 30, 2019 primarily related to operating lease right-of-use asset impairment charges in connection with the planned closure of 22 underperforming retail pharmacy stores in the first quarter of 2020; and
  - The increased prescription volume described previously.
- Operating expenses as a percentage of total revenues increased to 22.0% in the three months ended September 30, 2019 compared to 20.7% in the prior year. The increase in operating expenses as a percentage of total revenues was primarily driven by the increases in operating expenses described above.

Operating income and adjusted operating income

- Operating income decreased $396 million, or 26.6%, and adjusted operating income decreased $106 million, or 6.5%, in the three months ended September 30, 2019 compared to the prior year. Operating income and adjusted operating income were both negatively impacted by continued reimbursement pressure, partially offset by increased prescription volume and improved front store margin. The decrease in operating income also was driven by the $205 million pre-tax loss on the sale of Onofre and the $96 million store rationalization charge, each recorded in the three months ended September 30, 2019.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
  - The Company's pharmacy operating income has been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC Segment. If the reimbursement pressure accelerates, the Company may not be able grow revenues, and its operating income could be adversely affected.
  - The increased use of generic drugs has positively impacted the Company's operating income but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which the Company expects to continue, reduces the benefit the Company realizes from brand to generic drug conversions.

Commentary - Nine Months Ended September 30, 2019 vs. 2018

Revenues

- Total revenues increased $2.1 billion, or 3.3%, to $64.0 billion in the nine months ended September 30, 2019 compared to the prior year. The increase was primarily driven by increased prescription volume and brand name drug price inflation, partially offset by continued reimbursement pressure and an increased generic dispensing rate.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
  - Front store same store sales increased 1.3% in the nine months ended September 30, 2019 compared to the prior year. The increase in front store sales in 2019 was primarily driven by increases in health and beauty product sales, which benefited from continued strength in cough and cold products.
  - Pharmacy same store sales increased 4.7% in the nine months ended September 30, 2019 compared to the prior year. The increase was driven by the 7.3% increase in pharmacy same store prescription volumes on a 30-day equivalent basis driven mainly by (i) continued adoption of patient care programs, (ii) collaborations with PBMs and (iii) the Company's preferred status in a number of Medicare Part D networks.
  - Pharmacy revenue continues to be adversely affected by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 88.7% in the nine months ended September 30, 2019 compared to 87.8% in the prior year. Pharmacy revenue growth also has been negatively affected by continued reimbursement pressure.

Operating expenses

- Operating expenses increased $809 million, or 6.3%, in the nine months ended September 30, 2019 compared to the prior year, primarily due to the following:
  - Store rationalization charges of $231 million recorded in the nine months ended September 30, 2019 primarily related to operating lease right-of-use asset impairment charges in connection with the planned closure of underperforming retail pharmacy stores in the second quarter of 2019 and the first quarter of 2020;
  - The $205 million pre-tax loss on the sale of Onofre, which occurred on July 1, 2019;
  - The investment of a portion of the savings from the TCJA in wages and benefits; and
  - The increased prescription volume described previously, partially offset by:
  - The absence of the $86 million pre-tax loss on the sale of the Company's RxCrossroads subsidiary recorded in the nine months ended September 30, 2018.
- Operating expenses as a percentage of total revenues increased to 21.3% in the nine months ended September 30, 2019 compared to 20.7% in the prior year. The increase in operating expenses as a percentage of total revenues was primarily driven by the increases in operating expenses described above.

Operating income and adjusted operating income

- Operating income increased $3.0 billion, or 336.4%, and adjusted operating income decreased $605 million, or 11.5%, in the nine months ended September 30, 2019 compared to the prior year. The increase in operating income was primarily due to the absence of the $3.9 billion pre-tax goodwill impairment charge related to the LTC reporting unit and the $86 million pre-tax loss on the sale of the Company's RxCrossroads subsidiary recorded in the nine months ended September 30, 2018, partially offset by the $231 million of store rationalization charges and the $205 million pre-tax loss on the sale of Onofre recorded in the nine months ended September 30, 2019. Operating income and adjusted operating income were both negatively impacted by continued reimbursement pressure and increased operating expenses primarily driven by the investment of a portion of the savings from the TCJA in wages and benefits, partially offset by increased prescription volume and improved front store margin.

Health Care Benefits Segment

For periods prior to the Aetna Acquisition (which occurred on November 28, 2018), the Health Care Benefits segment consisted solely of the Company's SilverScript PDP business. The following table summarizes the Health Care Benefits segment's performance for the respective periods:

	Three Months Ended September 30,		Nine Months Ended September 30,		Change			
					Three Months Ended September 30, 2019 vs 2018		Nine Months Ended September 30, 2019 vs 2018	
In millions, except percentages	2019	2018	2019	2018	$	%	$	%
Revenues:								
Premiums	$ 15,507	$ 627	$ 47,543	$ 2,684	$ 14,880	2,373.2%	$ 44,859	1,671.3%
Services	1,528	10	4,453	29	1,518	15,180.0%	4,424	15,255.2%
Net investment income	146	4	458	10	142	3,550.0%	448	4,480.0%
Total revenues	17,181	641	52,454	2,723	16,540	2,580.3%	49,731	1,826.3%
Benefit costs	12,914	439	39,815	2,399	12,475	2,841.7%	37,416	1,559.6%
MBR (Benefit costs as a % of premium revenues) (1)	83.3%	NM	83.7%	NM				
Operating expenses	$ 3,231	$ 128	$ 9,386	$ 388	$ 3,103	2,424.2%	$ 8,998	2,319.1%
Operating expenses as a % of total revenues	18.8%	20.0%	17.9%	14.2%				
Operating income (loss)	$ 1,036	$ 74	$ 3,253	$ (64)	$ 962	1,300.0%	$ 3,317	5,182.8%
Operating income (loss) as a % of total revenues (2)	6.0%	11.5%	6.2%	NM				
Adjusted operating income (loss) (2) (3)	$ 1,423	$ 75	$ 4,423	$ (62)	$ 1,348	NM	$ 4,485	NM
Adjusted operating income (loss) as a % of total revenues (2)	8.3%	11.7%	8.4%	NM				

(1) The Health Care Benefits segment for the three and nine months ended September 30, 2018 consisted solely of the Company's SilverScript PDP business. Accordingly, the MBRs for the three and nine months ended September 30, 2018 are not meaningful ("NM") and are not directly comparable to the MBRs for the three and nine months ended September 30, 2019.
(2) Percentages are not meaningful.
(3) See "Segment Analysis" above in this report for a reconciliation of operating income (loss) (GAAP measure) to adjusted operating income (loss) for the Health Care Benefits segment.

Commentary - Three Months Ended September 30, 2019 vs. 2018

Revenues

- Total revenues increased $16.5 billion for the three months ended September 30, 2019 compared to the prior year primarily driven by the Aetna Acquisition.

Operating expenses

- Operating expenses in the Health Care Benefits segment include selling, general and administrative expenses and depreciation and amortization expenses.
- Operating expenses increased $3.1 billion in the three months ended September 30, 2019 compared to the prior year primarily driven by the Aetna Acquisition (including the amortization of intangible assets).

Operating income and adjusted operating income

- Operating income and adjusted operating income increased $962 million and $1.3 billion, respectively, in the three months ended September 30, 2019 compared to the prior year. The increases were primarily driven by the Aetna Acquisition. The increase in operating income was partially offset by an increase in intangible asset amortization related to the Aetna Acquisition.

Commentary - Nine Months Ended September 30, 2019 vs. 2018

Revenues

- Total revenues increased $49.7 billion for the nine months ended September 30, 2019 compared to the prior year primarily driven by the Aetna Acquisition.

Operating expenses

- Operating expenses increased $9.0 billion in the nine months ended September 30, 2019 compared to the prior year primarily driven by the Aetna Acquisition (including the amortization of intangible assets).

Operating income (loss) and adjusted operating income (loss)

- Operating income and adjusted operating income increased $3.3 billion and $4.5 billion, respectively, in the nine months ended September 30, 2019 compared to the prior year. The increases were primarily driven by the Aetna Acquisition. The increase in operating income was partially offset by an increase in intangible asset amortization related to the Aetna Acquisition. Operating loss and adjusted operating loss for the nine months ended September 30, 2018 reflect the seasonality of earnings for the Company's SilverScript PDP business. The quarterly earnings of the Company's SilverScript PDP business generally increase as the year progresses.

The following table summarizes the Health Care Benefits segment's medical membership for the respective periods:

	September 30, 2019			June 30, 2019			December 31, 2018		
In thousands	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**	**Insured**	**ASC**	**Total**
Medical membership:									
Commercial	3,560	14,159	17,719	3,571	14,276	17,847	3,871	13,888	17,759
Medicare Advantage	2,304	—	2,304	2,264	—	2,264	1,758	—	1,758
Medicare Supplement	842	—	842	819	—	819	793	—	793
Medicaid	1,382	562	1,944	1,344	562	1,906	1,128	663	1,791
Total medical membership	8,088	14,721	22,809	7,998	14,838	22,836	7,550	14,551	22,101
Supplemental membership information:									
Medicare Prescription Drug Plan (standalone) (1)			5,998			6,004			6,134

(1) Represents the Company's SilverScript PDP membership only. Excludes 2.5 million, 2.5 million and 2.3 million members as of September 30, 2019, June 30, 2019, and December 31, 2018, respectively, related to Aetna's standalone PDPs that were sold effective December 31, 2018. The Company will retain the financial results of the divested plans through 2019 through a reinsurance agreement.

Medical Membership

Medical membership as of September 30, 2019 remained relatively consistent compared with June 30, 2019, reflecting increases in Medicare and Medicaid products, offset by declines in Commercial products. Medical membership as of September 30, 2019 increased compared with December 31, 2018, reflecting increases in Medicare, Commercial ASC and Medicaid products, partially offset by declines in Commercial Insured products.

Medicare Update

On April 1, 2019, the United States Centers for Medicare & Medicaid Services ("CMS") issued its final notice detailing final 2020 Medicare Advantage benchmark payment rates (the "Final Notice"). Overall the Company projects the benchmark rates in the Final Notice will increase funding for its Medicare Advantage business, excluding the impact of the health insurer fee, by approximately 2.0% in 2020 compared to 2019.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Plans must have a star rating of four or higher (out of five) to qualify for bonus payments. CMS released the Company's 2020 star ratings in October 2019. The Company's 2020 star ratings will be used to determine which of the Company's Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2021. Based on the Company's membership at September 1, 2019, 83% of the Company's Medicare Advantage members were in plans with 2020 star ratings of at least 4.0 stars, compared to 79% of Aetna's Medicare Advantage members being in plans with 2019 star ratings of at least 4.0 stars based on Aetna's membership at September 1, 2018.

Corporate/Other Segment

Commentary - Three Months Ended September 30, 2019 vs. 2018

Revenues

- Total revenues decreased $65 million in the three months ended September 30, 2019 compared to the prior year.
- In 2019, revenues relate to products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, that were acquired in the Aetna Acquisition. Revenues in the three months ended September 30, 2019 include $32 million of realized capital gains, primarily related to the sale of debt securities and other invested assets. In 2018, revenues relate to interest income on the proceeds from the $40 billion of 2018 Notes issued to partially fund the Aetna Acquisition.

Operating expenses

- Operating expenses within the Corporate/Other segment include certain aspects of costs related to executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments and acquisition-related transaction and integration costs. After the Aetna Acquisition Date, such operating expenses also include operating costs to support the large case pensions and long-term care insurance products acquired in the Aetna Acquisition.
- Operating expenses increased $229 million in the three months ended September 30, 2019 compared to the prior year. The increase was primarily driven by incremental operating expenses associated with the Company's investments in transformation and modernization and an increase in acquisition-related integration costs of $45 million in the three months ended September 30, 2019 compared to the prior period.

Commentary - Nine Months Ended September 30, 2019 vs. 2018

Revenues

- Total revenues decreased $52 million in the nine months ended September 30, 2019 compared to the prior year.
- In 2019, revenues relate to products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, that were acquired in the Aetna Acquisition. Revenues in the nine months ended September 30, 2019 include $107 million of realized capital gains, primarily related to the sale of debt securities and other invested assets. In 2018, revenues relate to interest income on the proceeds from the $40 billion of 2018 Notes issued to partially fund the Aetna Acquisition.

Operating expenses

- Operating expenses increased $662 million in the nine months ended September 30, 2019 compared to the prior year. The increase was primarily driven by incremental operating expenses associated with the Company's investments in transformation and modernization and an increase in acquisition-related integration costs of $220 million in the nine months ended September 30, 2019 compared to the prior period.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, sale-leaseback program, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives. As of September 30, 2019, the Company had approximately $5.2 billion in cash and cash equivalents, approximately $1.2 billion of which was held by the parent company or nonrestricted subsidiaries.

The net change in cash, cash equivalents and restricted cash is as follows:

In millions	Nine Months Ended September 30, 2019	Nine Months Ended September 30, 2018	Change $	Change %
Net cash provided by operating activities	$ 10,214	$ 6,386	$ 3,828	59.9 %
Net cash used in investing activities	(2,630)	(1,386)	(1,244)	89.8 %
Net cash provided by (used in) financing activities	(6,410)	34,927	(41,337)	(118.4)%
Net increase in cash, cash equivalents and restricted cash	$ 1,174	$ 39,927	$ (38,753)	97.1 %

Commentary

- *Net cash provided by operating activities* increased by $3.8 billion in the nine months ended September 30, 2019 compared to the prior year due primarily to the Aetna Acquisition as well as improved performance in the Pharmacy Services and Retail/LTC segments.
- *Net cash used in investing activities* increased by $1.2 billion in the nine months ended September 30, 2019 compared to the prior year due primarily to the nine months ended September 30, 2018 reflecting $725 million in proceeds from the sale of RxCrossroads and increased purchases of property and equipment in the nine months ended September 30, 2019 compared to the prior year.
- *Net cash used in financing activities* was $6.4 billion in the nine months ended September 30, 2019 compared to net cash provided by financing activities of $34.9 billion in the prior year. The decrease in cash provided by financing activities primarily related to long-term borrowings during 2018 to partially fund the Aetna Acquisition, as well as debt repayments during 2019 including (i) the repayment of $4.0 billion of its outstanding senior notes pursuant to tender offers for such outstanding senior notes, (ii) $3.0 billion in repayments of the term loan used to partially fund the Aetna Acquisition and (iii) the repayment of $1.2 billion aggregate principal amount of senior notes upon maturity. The decrease was partially offset by the issuance of $3.5 billion of senior notes during the nine months ended September 30, 2019.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company had approximately $1.1 billion of commercial paper outstanding at a weighted average interest rate of 2.26% as of September 30, 2019. In connection with its commercial paper program, the Company maintains a $1.0 billion 364-day unsecured back-up revolving credit facility, which expires on May 14, 2020, a $1.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 18, 2022, a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 17, 2023, and a $2.0 billion, five-year unsecured back-up revolving credit facility, which expires on May 16, 2024. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03%, regardless of usage. As of September 30, 2019, there were no borrowings outstanding under any of the back-up credit facilities.

Bridge Loan Facility
On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a $49.0 billion unsecured bridge loan facility commitment. The Company paid $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. On March 9, 2018, the Company issued the 2018 Notes with an aggregate principal amount of $40.0 billion (see "Long-term Borrowings - 2018 Notes" below). At that time, the bridge loan facility commitment was reduced to $4.0 billion, and the Company paid $8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded $2 million and $171 million of amortization of the bridge loan facility commitment fees during the three and nine months ended September 30, 2018, respectively, which was recorded in interest expense in the unaudited condensed consolidated statement of operations. On October 26, 2018, the Company entered into a $4.0 billion unsecured 364-day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the $4.0 billion unsecured 364-day bridge term loan agreement terminated.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the Federal Home Loan Bank of Boston (the "FHLBB"). As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral

requirements. The maximum borrowing capacity available from the FHLBB as of September 30, 2019, was approximately $870 million. As of September 30, 2019, there were no outstanding advances from the FHLBB.

Long-term Borrowings

2019 Notes
On August 15, 2019, the Company issued $1.0 billion aggregate principal amount of 2.625% unsecured senior notes due August 15, 2024, $750 million aggregate principal amount of 3% unsecured senior notes due August 15, 2026 and $1.75 billion aggregate principal amount of 3.25% unsecured senior notes due August 15, 2029 (collectively, the "2019 Notes") for total proceeds of approximately $3.5 billion, net of discounts and underwriting fees. The net proceeds of the 2019 Notes were used to repay certain of the Company's outstanding debt.

Beginning in July 2019, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of the 2019 Notes. In connection with the issuance of the 2019 Notes, the Company terminated all outstanding cash flow hedges. The Company paid a net amount of $25 million to the hedge counterparties upon termination, which was recorded as a loss, net of tax, of $18 million in accumulated other comprehensive income and will be reclassified as interest expense over the life of the 2019 Notes. See Note 9 "Other Comprehensive Income (Loss)" to the unaudited condensed consolidated financial statements for additional information.

Early Extinguishment of Debt
In August 2019, the Company purchased $4.0 billion of its outstanding senior notes through cash tender offers. The senior notes purchased included the following: $1.3 billion of its 3.125% senior notes due 2020, $723 million of its floating rate notes due 2020, $328 million of its 4.125% senior notes due 2021, $297 million of 4.125% senior notes due 2021 issued by Aetna, $413 million of 5.45% senior notes due 2021 issued by Coventry Health Care, Inc., a wholly-owned subsidiary of Aetna and $962 million of its 3.35% senior notes due 2021. In connection with the purchase of such senior notes, the Company paid a premium of $76 million in excess of the aggregate principal amount of the senior notes that were purchased, incurred $8 million in fees and recognized a net gain of $5 million on the write-off of net unamortized deferred financing premiums, for a net loss on early extinguishment of debt of $79 million.

2018 Notes
On March 9, 2018, the Company issued an aggregate of $40.0 billion in principal amount of the 2018 Notes for total proceeds of approximately $39.4 billion, net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes consisted of the following at the time of issuance:

In millions	
3.125% senior notes due March 2020	$ 2,000
Floating rate notes due March 2020	1,000
3.35% senior notes due March 2021	3,000
Floating rate notes due March 2021	1,000
3.7% senior notes due March 2023	6,000
4.1% senior notes due March 2025	5,000
4.3% senior notes due March 2028	9,000
4.78% senior notes due March 2038	5,000
5.05% senior notes due March 2048	8,000
Total debt principal	$ 40,000

Term Loan Agreement
On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a $5.0 billion term loan agreement. The term loan agreement allowed for borrowings at various rates that were dependent, in part, on the Company's debt ratings. In connection with the Aetna Acquisition, the Company borrowed $5.0 billion (a $3.0 billion three-year tranche and a $2.0 billion five-year tranche) under the term loan agreement in November 2018. The Company terminated the $2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. The Company made payments of $500 million in March 2019, $1.0 billion in May 2019 and $1.5 billion in July 2019 on the three-year tranche, and terminated the three-year tranche and the term loan agreement with the final repayment of the borrowing in July 2019. As of September 30, 2019, the Company had no amount outstanding under the term loan agreement.

Aetna Related Debt

Upon the closing of the Aetna Acquisition, the Company assumed long-term debt with a fair value of $8.1 billion with stated interest rates ranging from 2.2% to 6.75%.

Debt Covenants

The Company's back-up revolving credit facilities, unsecured senior notes and unsecured floating rate notes contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit ratings. The covenants do not materially affect the Company's financial or operating flexibility. As of September 30, 2019, the Company was in compliance with all of its debt covenants.

Debt Ratings

As of September 30, 2019, the Company's long-term debt was rated "Baa2" by Moody's and "BBB" by Standard & Poor's ("S&P"), and its commercial paper program was rated "P-2" by Moody's and "A-2" by S&P. In assessing the Company's credit strength, the Company believes that both Moody's and S&P considered, among other things, the Company's capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody's and/or S&P. The Company's debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

Share Repurchase Program

During the nine months ended September 30, 2019 and 2018, the Company did not repurchase any shares of common stock. See Note 8 ''Shareholders' Equity'' to the unaudited condensed consolidated financial statements for additional information on the Company's share repurchase program.

Off-Balance Sheet Arrangements

See Note 12 ''Commitments and Contingencies'' to the unaudited condensed consolidated financial statements for information on the Company's lease guarantees.

Critical Accounting Policies

The Company prepares the unaudited condensed consolidated financial statements in conformity with accounting principles generally accepted in the United States of America, which require management to make certain estimates and apply judgment. Estimates and judgments are based on historical experience, current trends and other factors that management believes to be important at the time the unaudited condensed consolidated financial statements are prepared. On a regular basis, the Company reviews its accounting policies and how they are applied and disclosed in the unaudited condensed consolidated financial statements. While the Company believes the historical experience, current trends and other factors considered by management support the preparation of the unaudited condensed consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from estimates, and such differences could be material.

Leases

Effective January 1, 2019, the Company adopted ASU 2016-02, *Leases* (Topic 842). Under this accounting standard, lessees are required to recognize a right-of-use asset and a lease liability for virtually all of their leases (other than leases that meet the definition of a short-term lease). The liability is equal to the present value of lease payments. The asset is based on the liability, subject to certain adjustments, such as for initial direct costs. For income statement purposes, a dual model was retained, requiring leases to be classified as either operating or finance leases. Operating leases result in straight-line expense (similar to operating leases under the prior accounting standard) while finance leases result in a front-loaded expense pattern (similar to capital leases under the prior accounting standard). Lessor accounting is similar to the prior model, but updated to align with certain changes to the lessee model (e.g., certain definitions, such as initial direct costs, have been updated) and the new revenue recognition standard that was adopted in 2018. See the New Accounting Pronouncements Recently Adopted section of Note 1 ''Significant Accounting Policies'' to the unaudited condensed consolidated financial statements for a detailed discussion of the adoption of this new accounting standard.

Goodwill

During the three months ended September 30, 2019, the Company performed its required annual impairment tests of goodwill. The results of these impairment tests indicated that there was no impairment of goodwill. The goodwill impairment tests resulted in the fair values of all of the Company's reporting units exceeding their carrying values by significant margins, with the exception of the Commercial Business and LTC reporting units, which exceeded their carrying values by approximately 4% and 9%, respectively.

The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. The determination of the fair value of the reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include, but are not limited to, the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes; discount rates; terminal growth rates; and forecasts of revenue, operating profit, depreciation and amortization, income taxes, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, the Company considers each reporting unit's historical results and current operating trends and the Company's consolidated revenues, profitability and cash flow results, forecasts and industry trends. The Company's estimates can be affected by a number of factors, including, but not limited to, general economic and regulatory conditions, the risk-free interest rate environment, the Company's market capitalization, efforts of customers and payers to reduce costs, including their prescription drug costs, and/or increase member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

As of the Aetna Acquisition Date, the Company added the Health Care Benefits segment which included the Commercial Business reporting unit. The transaction was accounted for using the acquisition method of accounting which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. As a result, at the time of the acquisition the fair value of the Commercial Business reporting unit was equal to its carrying value. Given the close proximity of the Aetna Acquisition Date to the 2019 annual impairment test of goodwill, as expected, the fair value of the Commercial Business reporting unit remained relatively in line with the carrying value of the reporting unit.

During 2018, the LTC reporting unit continued to experience industry-wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare. Those challenges included lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a projected deterioration in the financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, an interim goodwill impairment test was performed during the fourth quarter of 2018. The results of that impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion goodwill impairment charge in the fourth quarter of 2018.

In 2018, the fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, changes in risk-free interest rates and lower market multiples of peer group companies also contributed to the amount of the 2018 goodwill impairment charges.

Although the Company believes the financial projections used to determine the fair value of the LTC reporting unit in the third quarter of 2019 were reasonable and achievable, the LTC reporting unit may continue to face challenges that may affect the Company's ability to grow the LTC reporting unit's business at the rate estimated when such goodwill impairment test was performed. These challenges and some of the key assumptions included in the Company's financial projections to determine the estimated fair value of the LTC reporting unit include client retention rates, occupancy rates in skilled nursing facilities, the financial health of skilled nursing facility customers, facility reimbursement pressures, the Company's ability to execute its senior living initiative, the Company's ability to make acquisitions and integrate those businesses into its LTC operations in an orderly manner, as well as the Company's ability to extract cost savings from labor productivity and other initiatives. The fair value of the LTC reporting unit also is dependent on market multiples of peer group companies and the risk-free interest rate environment, which impacts the discount rate used in the discounted cash flow valuation method. If the Company does not achieve its forecasts, it is reasonably possible in the near term that the goodwill of the LTC reporting unit could be deemed to be impaired again by a material amount. The balance of goodwill for the LTC reporting unit at September 30, 2019 was approximately $431 million.

For a full description of the Company's other critical accounting policies, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" for the year ended December 31, 2018, which was revised to reflect the Company's segment realignment and is included in Exhibit 99.2 to the August 2019 8-K.

Cautionary Statement Concerning Forward-Looking Statements

The Private Securities Litigation Reform Act of 1995 (the "Reform Act") provides a safe harbor for forward-looking statements made by or on behalf of the Company. In addition, the Company and its representatives may, from time to time, make written or verbal forward-looking statements, including statements contained in the Company's filings with the SEC and in its reports to stockholders, press releases, webcasts, conference calls, meetings and other communications. Generally, the inclusion of the words "anticipate," "believe," "estimate," "expect," "intend," "project," "should," "will" and similar expressions identify statements that constitute forward-looking statements. All statements addressing operating performance of CVS Health Corporation or any subsidiary, events or developments that the Company projects, expects or anticipates will occur in the future, including statements relating to corporate strategy; revenue growth; adjusted revenue growth, earnings or earnings per common share growth; adjusted operating income or adjusted earnings per common share growth; free cash flow; debt ratings; inventory levels; inventory turn and loss rates; store development; relocations and new market entries; retail pharmacy business, sales results and/or trends and operations; PBM business, sales results and/or trends and operations; specialty pharmacy business, sales results and/or trends and operations; LTC pharmacy business, sales results and/or trends and operations; Health Care Benefits business, sales results and/or trends, medical cost trends, medical membership growth, medical benefit ratios and operations; the Company's ability to attract or retain customers and clients; Medicare Advantage and/or Medicare Part D competitive bidding, enrollment and operations; new product development; and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future operating results or events, are forward-looking statements within the meaning of the Reform Act.

The forward-looking statements are and will be based upon management's then-current views and assumptions regarding future events and operating performance, and are applicable only as of the dates of such statements. The Company undertakes no obligation to update or revise any forward-looking statements, whether as a result of new information, future events, or otherwise.

By their nature, all forward-looking statements involve risks and uncertainties. Actual results may differ materially from those contemplated by the forward-looking statements for a number of reasons as described in the Company's SEC filings, including those set forth in the Risk Factors section of the Company's Annual Report on Form 10-K for the year ended December 31, 2018, and including, but not limited to:

- *Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond.*
- *Our brand and reputation are two of our most important assets; negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, results of operations, cash flows and prospects.*
- *Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.*

- *We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our future performance.*
- *We are subject to potential changes in public policy, laws and regulations, including reform of the United States health care system, that can adversely affect the markets for our products and services and our businesses, operations, results of operations, cash flows and prospects.*
- *Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, or we may not be able to implement our strategy and related strategic projects.*
- *Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our businesses.*
- *Gross margins in the industries in which we operate may decline.*
- *Our results of operations are affected by the health of the economy in general and in the geographies we serve.*
- *We operate in a highly competitive business environment. Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and results of operations will be adversely affected. We may not be able to obtain appropriate pricing on new or renewal business.*
- *We may lose clients and/or fail to win new business. If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care Benefits segment, our results of operations, financial condition and cash flows could be materially and adversely affected.*
- *We are exposed to risks relating to the solvency of our customers and of other insurers.*
- *We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs that we purchase and sell.*
- *We face risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription drug products.*
- *Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM business.*
- *Product liability, product recall or personal injury issues could damage our reputation.*
- *We face challenges in growing our Medicare Advantage and Medicare Part D membership.*
- *We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.*
- *A change in our Health Care Benefits product mix may adversely affect our profit margins.*
- *We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's results of operations. There can be no assurance that the future health care and other benefit costs of our Insured Health Care Benefits products will not exceed our projections.*
- *A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our Health Care Benefits segment's results of operations and competitiveness will be adversely affected.*
- *The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our results of operations could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.*
- *Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs. We cannot predict whether or when any such events will occur.*
- *Legislative and regulatory changes could create significant challenges to our Medicare Advantage and Medicare Part D revenues and results of operations, and proposed changes to these programs could create significant additional challenges. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or results of operations.*
- *We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and results of operations and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.*
- *Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our results of operations.*
- *Our business activities are highly regulated. Our Pharmacy Services, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our businesses. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.*

- *If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our businesses, results of operations, cash flows and/or financial condition.*
- *Our litigation and regulatory risk profile are changing as a result of the Aetna Acquisition and as we offer new products and services and expand in business areas beyond our historical core businesses of Retail/LTC and Pharmacy Services.*
- *We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and results of operations.*
- *We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.*
- *We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.*
- *Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues. The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, results of operations and cash flows. In addition, an extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, results of operations and cash flows.*
- *Our results of operations may be adversely affected by changes in laws and policies governing employers and by union organizing activity.*
- *We must develop and maintain a relevant omni-channel experience for our retail customers.*
- *We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands. If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow our customer base may be adversely affected.*
- *In order to be competitive in the increasingly consumer-oriented marketplace for our health care products and services, we will need to develop and deploy consumer-friendly products and services and make investments in consumer engagement, reduce our cost structure and compete successfully with new entrants into our businesses. If we are unsuccessful, our future growth and profitability may be adversely affected.*
- *Our results of operations may be adversely affected if we are unable to contract with manufacturers, providers, suppliers and vendors on competitive terms and develop and maintain attractive networks with high quality providers.*
- *If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.*
- *Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.*
- *We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.*
- *Customers, particularly large sophisticated customers, expect us to implement their contracts and onboard their employees and members efficiently and effectively. Failure to do so could adversely affect our reputation, businesses, results of operations, cash flows and prospects. If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership and customer base will be adversely affected.*
- *We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.*
- *Our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and results of operations.*
- *We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.*
- *The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, results of operations and cash flows.*

- *Our business success and results of operations depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.*
- *Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.*
- *We also face other risks that could adversely affect our businesses, results of operations, financial condition and/or cash flows, which include:*
  - *Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;*
  - *Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our results of operations and/or a deterioration in the soundness and accuracy of our reported results of operations; and*
  - *Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including Aetna's divested standalone Medicare Part D, domestic group life insurance, group disability insurance and absence management businesses.*
- *Goodwill and other intangible assets could, in the future, become impaired.*
- *We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, cash flows, financial condition and results of operations.*
- *Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our results of operations and/or our financial condition.*
- *We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve our objectives as a combined company.*
- *The Aetna Acquisition may not be accretive, and may be dilutive, to our earnings per share, which may adversely affect our stock price.*
- *We may fail to successfully combine the businesses and operations of CVS Health and Aetna to realize the anticipated benefits and cost savings of the Aetna Acquisition within the anticipated timeframe or at all, which could adversely affect our stock price.*
- *Our future results may be adversely impacted if we do not effectively manage our expanded operations following completion of the Aetna Acquisition.*
- *We may have difficulty attracting, motivating and retaining executives and other key employees following completion of the Aetna Acquisition.*
- *The Aetna integration process could disrupt our ongoing businesses and/or operations.*
- *Our indebtedness following completion of the Aetna Acquisition is substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility and increase our borrowing costs.*
- *We will continue to incur significant integration-related costs in connection with the Aetna Acquisition.*
- *We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.*
- *We may be unable to successfully integrate companies we acquire.*
- *As a result of our expanded international operations, we face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations.*

The foregoing list is not exhaustive. There can be no assurance that the Company has correctly identified all the risks that affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. Should any risks or uncertainties develop into actual events, these developments could have a material adverse effect on the Company's businesses, operating results, cash flows and/or financial condition as well as the market price for the Company's common shares. For these reasons, you are cautioned not to place undue reliance on the Company's forward-looking statements.

Item 3. Quantitative and Qualitative Disclosures About Market Risk

The Company has not experienced any material changes in exposures to market risk since December 31, 2018. See the information contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations - Quantitative and Qualitative Disclosures About Market Risk" in Exhibit 99.2 to the Company's Current Report on Form 8-K filed with the SEC on August 8, 2019, for a discussion of the Company's exposures to market risk.

Item 4. Controls and Procedures

Evaluation of disclosure controls and procedures: The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Securities Exchange Act Rules 13a-15(f) and 15d-15(f)) as of September 30, 2019, have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective and designed to provide reasonable assurance that material information relating to the Company and its subsidiaries would be made known to such officers on a timely basis.

Changes in internal control over financial reporting: On November 28, 2018, the Company completed its acquisition of Aetna. The Company is in the process of integrating the historical internal control over financial reporting of Aetna with the rest of the Company.

Other than the foregoing, there has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred in the three months ended September 30, 2019 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Part II. Other Information

Item 1. Legal Proceedings

The information contained in Note 12 ''Commitments and Contingencies'' contained in "Notes to Condensed Consolidated Financial Statements" in Part I, Item 1 of this Quarterly Report on Form 10-Q is incorporated by reference herein.

Item 1A. Risk Factors

There have been no material changes to the "Risk Factors" disclosed in Part I, Item 1A of the Company's Annual Report on Form 10-K for the year ended December 31, 2018. Those risk factors could adversely affect the Company's businesses, operating results, cash flows and/or financial condition as well as the market price of the Company's common shares.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

(c) Stock Repurchases

The following table presents the total number of shares purchased in the three months ended September 30, 2019, the average price paid per share and the approximate dollar value of shares that still could have been purchased at the end of the applicable fiscal period, pursuant to the 2016 Repurchase Program. See Note 8 ''Shareholders' Equity'' contained in "Notes to Condensed Consolidated Financial Statements" in Part I, Item 1 of this Quarterly Report on Form 10-Q for additional information.

Fiscal Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs
July 1, 2019 through July 31, 2019	—	$ —	—	$ 13,869,392,446
August 1, 2019 through August 31, 2019	—	$ —	—	$ 13,869,392,446
September 1, 2019 through September 30, 2019	—	$ —	—	$ 13,869,392,446
	—		—	

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

Not Applicable.

Item 5. Other Information

Rule 10b5-1 Plan Election

On August 27, 2019, Larry J. Merlo, President and Chief Executive Officer of CVS Health Corporation, entered into a stock trading plan (the "Plan"). The Plan covers the exercise of options to purchase 314,713 shares of common stock of the Company between January 15, 2020 and April 1, 2020, which is the date the Plan expires. Mr. Merlo's option exercises will be accomplished through "sell to cover" transactions, meaning that Mr. Merlo will only sell enough shares to cover the exercise price and related taxes. The Plan was entered into for financial and tax planning purposes and to avoid forfeiture, and is consistent with Mr. Merlo's past practice of entering into a stock trading plan annually to address expiring stock options. The options covered by the Plan will expire on April 1, 2020 if they are not exercised.

The Plan is designed to satisfy Rule 10b5-1 under the Securities Exchange Act of 1934, as amended ("Rule 10b5-1"), and the Company's Insider Trading Policy and its Stock Ownership Guidelines. The Company does not undertake to report other Rule 10b5-1 trading plans that may be adopted by any officers, directors or other stockholders in the future, or to report any modifications or terminations of any publicly announced trading plan, including Mr. Merlo's Plan.

Item 6. Exhibits

The exhibits listed in this Item 6 are filed as part of this Quarterly Report on Form 10-Q. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

15	**Letter re: unaudited interim financial information**
15.1	Letter from Ernst & Young LLP acknowledging awareness of the use of a report dated November 6, 2019 related to their reviews of interim financial information.
31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.
31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.
32.2	Certification by the Chief Financial Officer.
101	
101	The following materials from the CVS Health Corporation Quarterly Report on Form 10-Q for the three and nine months ended September 30, 2019 formatted in Inline XBRL: (i) the Condensed Consolidated Statements of Operations, (ii) the Condensed Consolidated Statements of Comprehensive Income, (iii) the Condensed Consolidated Balance Sheets, (iv) the Condensed Consolidated Statements of Cash Flows, (v) the Condensed Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Condensed Consolidated Financial Statements. The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
104	
104	Cover Page Interactive Data File - The cover page from the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2019, formatted in Inline XBRL (included as Exhibit 101).

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

CVS HEALTH CORPORATION

Date: November 6, 2019

By: /s/ Eva C. Boratto
Eva C. Boratto
Executive Vice President and Chief Financial Officer

Exhibit 15.1

Letter re: Unaudited Interim Financial Information

November 6, 2019

To the Shareholders and the Board of Directors of CVS Health Corporation

We are aware of the incorporation by reference in the Registration Statements (Form S-3ASR No. 333-217596 and Form S-8 Nos. 333-230035, 333-228622, 333-167746, 333-217853, 333-208805, 333-141481, 333-139470, 333-63664, 333-91253, 333-49407, 333-34927, and 333-28043) of CVS Health Corporation of our report dated November 6, 2019, relating to the unaudited condensed consolidated interim financial statements of CVS Health Corporation that is included in its Form 10-Q for the quarter ended September 30, 2019.

/s/ Ernst & Young LLP

Boston, Massachusetts

Exhibit 31.1

Certification

I, Larry J. Merlo, President and Chief Executive Officer of CVS Health Corporation, certify that:

1. I have reviewed this quarterly report on Form 10-Q of CVS Health Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 6, 2019

/s/ LARRY J. MERLO

Larry J. Merlo

President and Chief Executive Officer

Exhibit 31.2

Certification

I, Eva C. Boratto, Executive Vice President and Chief Financial Officer of CVS Health Corporation, certify that:

1. I have reviewed this quarterly report on Form 10-Q of CVS Health Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 6, 2019

/s/ EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATION

The certification set forth below is being submitted in connection with the Quarterly Report of CVS Health Corporation (the "Company") on Form 10-Q for the period ended September 30, 2019 (the "Report") solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Larry J. Merlo, President and Chief Executive Officer of the Company, certify that, to the best of my knowledge:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: November 6, 2019

/s/ LARRY J. MERLO

Larry J. Merlo

President and Chief Executive Officer

Exhibit 32.2

CERTIFICATION

The certification set forth below is being submitted in connection with the Quarterly Report of CVS Health Corporation (the "Company") on Form 10-Q for the period ended September 30, 2019 (the "Report") solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Eva C. Boratto, Executive Vice President and Chief Financial Officer of the Company, certify that, to the best of my knowledge:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: November 6, 2019

/s/ EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Appendix E

Aetna Better Health® of West Virginia Certificate of Authority

West Virginia
Offices of the Insurance Commissioner

Certificate of Authority

Whereas, **COVENTRY HEALTH CARE OF WEST VIRGINIA, INC.**, a HMO of **WEST VIRGINIA**, has complied with all the necessary requirements of the laws of this State so as to entitle it to transact its appropriate business in **Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming** counties, in the State of West Virginia.

Therefore, I the undersigned, Insurance Commissioner of the State of West Virginia, pursuant to the authority vested in me by the laws of this State, do hereby authorize it to operate in the aforementioned counties in the State of West Virginia as defined in Chapter 33

HEALTH MAINTENANCE ORGANIZATION - ARTICLE 25A

of the 1931 Code of West Virginia as amended, in the State of West Virginia in accordance with the laws thereof until midnight on the 31st day of May, 2020, unless this license may be sooner suspended or revoked.

In Testimony Whereof, I have hereunto set my hand and affixed my seal of office at the City of Charleston this 1st day of June, 2019.

James A. Dodrill
Insurance Commissioner

NAIC # 95408

Legacy State ID # D003

Appendix F

eviCore Subcontractor Agreement .....App F-3

SKYGEN/Scion Dental Subcontractor Agreement .....App F-505

Vision Service Plan, Inc. Subcontractor Agreement .....App F-523

Cotiviti Subcontractor Agreement .....App F-571

Regulatory Compliance Addendum .....App F-831

Attached are four sample base Subcontractor agreements in support of Aetna's Medicaid managed care business in West Virginia. Our Subcontractor agreements also include a Regulatory Compliance Addendum (Addendum), to incorporate pertinent requirements of the state contract and state law. The current Addendum, approved by the Department on September 24, 2018, is attached as Appendix F, page 831. For any proposed new subcontractors, we will provide the Department with the Subcontractor agreement within the timeframe required.

eviCore Subcontractor Agreement

NATIONAL RADIOLOGY MANAGEMENT SERVICES AGREEMENT

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RADIOLOGY MANAGEMENT SERVICES AGREEMENT

This Radiology Management Services Agreement, as it may be amended from time to time (the "Agreement"), is made and entered into as of _____(the "Effective Date"), by and between (i) Aetna Medicaid Administrators LLC (formerly known as Schaller Anderson, LLC), on behalf of itself and its Affiliates (hereinafter "Company"); and (ii) MedSolutions, Inc., a Tennessee corporation with its principal place of business in Franklin, TN ("Delegated Entity"). Company and Provider may be referred to individually as a "Party" and collectively as the "Parties." Each state-specific **Individual Sites Regulatory Compliance Addendum** attached to this Agreement as **Exhibit A,** is expressly incorporated into this Agreement and is binding upon the Parties to this Agreement. In the event of any inconsistent or contrary language between any **Individual Sites Regulatory Compliance Addendum** and any other part of this Agreement, including, but not limited to, any other exhibits, attachments, schedules or amendments, the Parties agree that the provisions of the **Individual Sites Regulatory Compliance Addendum** shall prevail. Each **Individual Sites Regulatory Compliance Addendum** attached hereto as **Exhibit A** includes the State-Required Terms and Program Participation Requirements unique to the state identified in each such **Individual Sites Regulatory Compliance Addendum**. The Parties acknowledge that the Delegated Entity defined herein, provides Utilization Management Services as set forth in this Agreement and will comply with the applicable Individual Sites Regulatory Compliance Addendum provisions, as it pertains to Delegated Entity's scope of services. **Exhibit D, Addendum for Medicare-Medicaid Dual Eligible Members,** shall apply to all services rendered to such Members. Exhibit C is reserved.

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, Delegated Entity has established a program for Utilization Management including patient management and customer service which duties and obligations of the Parties related to such delegated services are set forth in the Delegated Patient Management Addendum and the Delegated Customer Service Addendum attached hereto and made a part of this Agreement hereof; and

WHEREAS, Company and Delegated Entity wish to contract for the provision of Utilization Management services ("UM Program") 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

1.1 Affiliate. The term "Affiliate," as it appears in this Agreement, refers to each Party's current Affiliates listed in **Exhibit B**, attached hereto and made a part of this Agreement hereof. Company Affiliates administer 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. Participating Providers provide and/or arrange for the provision of, services consistent with the terms of this Agreement, including each state-specific **Individual Sites Regulatory Compliance Addendum**. To the extent applicable, an Affiliate may be any corporation, partnership or other legal entity (including, as it concerns Company, any Plan identified herein) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with either Party. An Affiliate may also be an entity owned by a third-party for which Company provides services as third-party administrator (a "Third-Party Affiliate"). Such Third-Party Affiliates are so identified in Exhibit B.

1.2 Aetna or Company. Aetna Medicaid Administrators LLC (formerly known as Schaller Anderson, LLC), and its applicable Affiliates.

1.3 Applicable Law. Such federal, state, and local laws, rules and administrative regulations and guidance, including manuals, guidelines, operational policy letters, any CMS directions or instructions, and any directions or instructions that are adopted and/or published by any federal or state regulatory agency or any other governmental body with authority over Company and/or Delegated Entity, that relate to or apply to the parties' obligations under this Agreement.

1.4 Average Speed of Answer. Telephone calls placed by Providers measured from the time the caller chooses an option that results in the caller being placed in queue for response by a Call Center 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.

1.5 Board-Certified Radiologist. A radiologist who is certified by the American Board of Radiology and such certification is current.

1.6 Call Center Management. The process of monitoring and evaluating the appropriateness of handling calls regarding Patient Management Functions as described in this Agreement.

1.7 CMS. Centers for Medicare and Medicaid Services.

1.8 Clinical Review Criteria. The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by Delegated Entity to determine the medical necessity and appropriateness of Diagnostic Imaging Services.

1.9 Covered Diagnostic Imaging (DI) Services. Those Diagnostic Imaging Services that a Member is entitled to receive under the terms and conditions of a Plan.

1.10 Delegated Entity Services. The services to be performed by Delegated Entity as set forth in this Agreement and Exhibit 1 including Patient Management and Call Center Management Services.

1.11 Diagnostic Imaging Services. The services described in Attachment 1A to Exhibit 1.

1.12 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.

1.13 Emergency Services. Unless otherwise defined in the Member's Plan, the medically necessary services to preserve life or stabilize health, available on an inpatient basis, twenty-four (24) hours per day, seven (7) days a week.

1.14 Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

1.15 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).

1.16 HIPAA. Health Insurance Portability and Accountability Act of 1996.

1.17 HIPDB. Healthcare Integrity and Protection Data Bank.

1.18 Managed Member. A Member enrolled in a Plan that : (i) requires precertification of Diagnostic Imaging Services; and (ii) is located in a Company-defined market serviced and contracted by Delegated Entity pursuant to Exhibit 1 and any attached schedules.

1.19 Medically Necessary or Medical Necessity. Health care services that a physician, 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 recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

1.20 Member. An individual covered by or enrolled in a Plan and entitled to such Covered Services offered by the Plan.

1.21 Member 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 a Member. 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.

1.22 NCQA. National Committee for Quality Assurance.

1.23 NPDB. National Practitioner Data Bank.

1.24 Operational Date. For purposes of this Agreement and purposes of the Performance Measures, the Operational Date shall be, as to each Affiliate, the latter of January 1, 2014; the date upon with the applicable Government Sponsor approves commencement of services; the effective date listed on in Exhibit B, or an alternative date as agreed to by the Parties in writing.

1.25 Payor. An employer, insurer, health maintenance organization, labor union, employee benefit plan, organization or other person or entity that has agreed to be responsible for funding benefit payments for services and/or supplies provided to Members under the terms of a Plan.

1.26 Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility 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 Company's credentialing policies. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

1.27 Patient Management or "PM". The process of monitoring and evaluating on a prospective, concurrent and retrospective basis, the medical necessity and appropriateness of health care services that are provided by Providers to Members in accordance with the programs described in Exhibit 1. For the purpose of this agreement the terms Patient Management and Utilization Management may be used interchangeably.

1.28 Patient Management Notification. A process initiated by the Provider under which the Provider notifies the Delegated Entity of proposed procedures, treatments or referrals, and Delegated Enity issues an authorization for service.

1.29 Patient Management Records. All data, information, and documentation related to the Delegated Entity's performance of Patient Management.

1.30 Plan. A Member's healthcare benefits as set forth in the Member's Summary Plan Description, Certificate of Coverage, Evidence of Coverage, or other applicable coverage document.

1.31 Plan Sponsor. An entity that has contracted with Company to issue, administer, or service a Plan. Sponsors include, without limitation, employer groups sponsoring or offering self-funded Plans to their employees.

1.32 Precertification. A process of assessing the medical necessity and appropriateness of proposed services and level of service, such as inpatient hospitalizations, outpatient surgeries or diagnostic procedures, prior to the Provider rendering such services to the Member.

1.33 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, Patient Management Information, (whether written or oral) which are furnished or disclosed to Delegated Entity 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.

1.34 Provider. Any physician, hospital, hospital-based physician, skilled nursing facility or other individual or entity involved in the delivery of health care or ancillary services.

1.35 Radiology Provider. A duly licensed and qualified physician or free standing imaging center, who is under contract with and credentialed by Company to provide Diagnostic Imaging Services to Members.

1.36 Referring Physician. A physician in a specialty other than diagnostic radiology who orders diagnostic imaging examinations to aid in the diagnosis of disease or pathology for a patient in his or her care.

1.37 Related Party. A Party's parent, subsidiary, other affiliate, or any of their respective officers, directors, trustees, employees, agents, contractors, or other representatives.

1.38 Retrospective Review. A review conducted after services have been rendered to a Member and prior to an initial determination.

1.39 State Contract. Company's contract(s) with Government Sponsors to administer Plans or Government Programs identified in the **Program Participation Schedule**.

1.40 Telephone Abandon Rate. The number of callers who hang up after their call is queued for response but before the call center representative actually pulls them off the queue, divided by the total number of callers whose calls are queued

1.41 URAC. American Accreditation HealthCare Commission/Utilization Review Accreditation Commission.

2.0 Delegated Entity's Services

2.1 Services. Upon the terms and subject to the conditions of this Agreement, Delegated Entity shall provide the Delegated Entity Services. Delegated Entity Services shall include, without limitation, personnel, equipment, and other resources, responsibilities, and functions necessary to provide the Delegated Entity Services.

2.2 Standard of Care. Delegated Entity shall provide the Delegated Entity Services in accordance with generally accepted standards applicable to similarly situated vendors and the terms and conditions of this Agreement. Delegated Entity shall not 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 services required, or any other grounds prohibited by law or this Agreement.

2.3 Co-Branding. If applicable, Delegated Entity agrees to co-brand with Company for Delegated Entity Services to Members

2.4 Personnel and Staffing.

2.4.1 Delegated Entity shall maintain an experienced leadership team, with individual expertise in all areas of radiology services described in Exhibit 1, consisting of at least: one account representative assigned to each Company's local markets in which Delegated Entity provides Services. The names of all such individuals will be provided to Company upon request. Upon Company's reasonable request and if practicable to do so, Delegated Entity shall designate different personnel to service Company's account.

2.4.2 Delegated Entity shall assign adequate personnel to the Delegated Entity Services in a manner that meets or exceeds the standards and requirements of both NCQA and URAC applicable to the Services.

2.4.3 Delegated Entity will develop a strategy and staffing plan with dedicated account management staff in coordination with Company which will support the migration of Company's business prior to such transition.

2.4.4 Delegated Entity and Company shall collaborate on (i) communication efforts to Providers and Members regarding Company's selection of Delegated Entity and (ii) processes and protocols on interacting with Delegated Entity and Company's Covered Diagnostic Imaging Services.

2.5 Oversight. Delegated Entity agrees to allow Company to maintain reasonable oversight of the Patient Management and Call Center Management activities of Delegated Entity. Such oversight, which shall be a right and not an obligation of Company hereunder, shall at a minimum include:

2.5.1 Submission to Company of copies of Delegated Entity's written policies and procedures for Delegated Entity Services prior to implementation and at least once each year during the term of this Agreement ("Approved Policies") or as required by Government Sponsor. 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. Delegated Entity agrees to provide thirty (30) days prior written notice of any changes to Approved Policies or other timeline as defined by Company. In the event any changes to Approved Policies are material to the Delegated Entity Services then such policies and procedures are subject to written approval by Company prior to their implementation, which approval shall not be unreasonably withheld. Delegated Entity agrees to provide sixty (60) days prior written notice of material systems conversions or modifications by Delegated Entity or other timeline as defined by Company.

2.5.2 Permission for Company to conduct annual site visits upon thirty (30) calendar days prior written notice, or upon shorter notice in the event that Company determines a shorter period is necessary to ensure Company's compliance with CMS requirements, Government Sponsor or as may be necessary to satisfy Company obligations in Section 4.0 of this Agreement.

2.5.3 Permission for Company, Plan Sponsors, Government Sponsors with good cause, and federal, state, and local government authorities having jurisdiction, upon written request, to make a reasonable number of copies of all records and other papers materially relating to Delegated Entity' performance under this Agreement and Delegated Entity Services provided hereunder, including without limitation medical records (together "Services Data"). Copies of such requested Services Data shall be supplied within fourteen (14) calendar days of Delegated Entity' receipt of the request, where practicable or other timeline as defined by Company. Delegated Entity shall be relieved of its obligations hereunder if and only to the extent Delegated Entity's performance of such obligations would violate Applicable Law. Delegated Entity shall maintain any Services Data not returned to Company or destroyed pursuant to Section 8.2 below for the longer of seven (7) years after termination of this Agreement or the period required by Applicable Law or Government Sponsor and shall provide Company access to such Services Data for as long as it is maintained as provided in this Section 2.5.3.

2.5.4 Permission for Company, including Company's employees, agents, and representatives, to have reasonable access to Delegated Entity' books and records materially relating to Delegated Entity's performance under this Agreement for review, inspection, audit, and evaluations incident to and in accordance with this Agreement (including all Exhibits hereto). Company shall provide reasonable written notice in advance of inspecting records or other documentation. Delegated Entity shall cooperate with Company's reasonable requests during such review, inspection, audit and evaluation. Company shall conduct such reviews, inspections, audits and evaluations during normal business hours and in a manner such as to minimize disruption to Delegated Entity's business. Such review shall only apply to records and documentation relating to the parties' obligations under this Agreement and no documents or records shall be reviewed or disclosed without full compliance with all Applicable Law, including HIPAA (as defined in Section 7 below). Delegated Entity shall have permission to inspect records of the Company that are material to Delegated Entity's duties to perform Services or the Agreement Each party shall allow all applicable accrediting agencies, state regulatory agencies, and any other state or federal agencies regulating the transactions hereunder or their designees, to inspect, evaluate and duplicate any pertinent books, documents, papers and records involving transactions pertaining to this Agreement as required by Applicable Law. Any inspection or duplication of records will occur only during regular working hours upon written notice, which shall be not less than two (2) weeks, and shall take place at the site where the audited party maintains such records during the audited party's normal business hours unless otherwise permitted by law. The written notice shall describe the scope of the audit or review. The parties shall cooperate with each other and make all reasonable efforts to confine any audit to a reasonable length of time. Each party shall bear its own costs associated with any audit or inspection conducted in accordance with this Section 2.5.4.

2.5.5 Permission for federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization (collectively, "Permitted Parties"), to audit, during regular business hours upon at least ten (10) calendar days prior written notice, or upon shorter notice in the event that Company determines a shorter period is necessary to ensure Company's compliance with

Applicable Law or Government Sponsor, any and all documents and materials related to services rendered under this Agreement. Any such audit shall be permitted during the term of this Agreement and for a period of six (6) years thereafter, with each party responsible for its own expenses incurred related to such audit. In addition to the requirements of this Section 2.5.5, Delegated Entity agrees that, with respect to Medicare Plans, Permitted Parties shall be permitted to perform any such audit during the term of this Agreement and 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 Department of Health and Human Services ("HHS"), the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by Applicable Law. This Section 2.5.5 shall survive the termination of this Agreement, regardless of the cause of termination.

2.5.6 Permission for National Committee for Quality Assurance ("NCQA"), American Accreditation HealthCare Commission/Utilization Review Accreditation Commission ("URAC"), other accrediting organization to conduct on-site review of any documents related to services provided by Delegated Entity under this Agreement during an accreditation survey of Company by NCQA or URAC. Delegated Entity agrees to cooperate with any review of Company or a Plan conducted by an accrediting body or a Federal or state agency with authority over Company and/or the Plan, as applicable.

2.5.7 Delegated Entity agrees to provide information requested by Company to enable Company to respond to Member, regulator, Government Sponsor and provider inquiries. Delegated Entity agrees to provide data to Company as reasonably required by Company. In addition, Delegated Entity agrees that Company and Plan Sponsors shall have access to all data and information obtained, created or collected by Delegated Entity related to Members, including without limitation Member Confidential Information.

2.5.8 Submission to Company of mutually agreed upon periodic reports, on Delegated Entity Services provided by Delegated Entity. Said reports shall be provided in accordance with the Attachment 1 to Exhibit 1, including, when required by Company, certification of an executive officer of Delegated Entity as to the report's truth and accuracy, and at such other times as may be mutually agreed to by the Parties.

2.5.9 Delegated Entity agrees to provide, in a format reasonably acceptable to Company, timely, accurate, and appropriate data and information (including demographics) to enable Company to fulfill applicable accrediting organizations and Federal and state regulatory filing requirements, including HEDIS, Government Sponsor and CMS requirements.

2.5.10 Delegated Entity agrees to retain all data, information, records and documentation related to its performance of Delegated Entity Services for the longer of seven (7) years following the date of service or the period required by applicable state law. As required under Applicable Law, Delegated Entity agrees to provide Permitted Parties reasonable access to all Patient Management and/or Call Center Management activities. In addition to the requirements of this Section 2.5.10, with respect to Medicare Plans, Delegated Entity agrees to maintain Patient Management Records 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 designees complete an audit, or (iii) the period required by Applicable Law. This record retention provision, shall survive the termination of this Agreement, regardless of the cause giving rise to the termination.

2.6 Appeals. Delegated Entity agrees to cooperate reasonably with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicare appeals, Government Sponsor 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 or Government Sponsor. For avoidance of doubt, the final determination of appeals is not delegated to Delegated Entity unless Company specifically requests otherwise.

2.7 Performance Obligations. Provision of Delegated Entity Services shall be in accordance with the following or other metrics as defined by Company and Government Sponsor:

a. Average Speed of Answer for telephone calls placed by providers is 30 seconds or less. Average Speed of answer of telephone calls placed by 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 eighty-five percent (85%) 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 85% of the calls are to be answered within 30 seconds;

d. All calls placed to the Call Center shall be answered by a live person or an automated answering/forwarding system with no forced busy signal;

e. Delegated Entity will make available web-based precertification process online through secure web applications for Provider.

f. A quality program should include elements of internal random call monitoring with scoring criteria with a standard of 96.25 percent (96.25%).

g. Prior Authorization turnaround times as defined by Company and Government Sponsor and communicated to Delegated Entity in accordance with this Agreement.

h. Appeal review and resolution as defined by Company and Government Sponsor and communicated to Delegated Entity in accordance with this Agreement.

i. Submission of approval and/or denial letters in accordance with Company and Government Sponsor.

3.0 Representations, Warranties and Covenants of Delegated Entity

3.1 Delegated Entity's General Representations and Covenants. Delegated Entity represents, warrants and covenants to Company that:

a. It is, and will remain throughout the term of this Agreement, in good standing in all material respects under Applicable Law governing its existence and operations and that it is in substantial compliance with and shall continue to comply with Applicable Law that relates to the subject matter of this Agreement or the duties and obligations hereunder, including, but not limited to, those relating to Patient Management and Call Center Management;

b. It is, and all personnel are, in substantial compliance with any licensing, permitting, or other authorization requirements of, and agrees to maintain such substantial compliance under, applicable states for the express purpose of Delegated Entity's Services. In no event shall Company be liable for any fees, costs, or other expenses associated with the procurement and maintenance of any licenses, permits or other authorizations; or for Delegated Entity' failure to procure, maintain, or comply with the terms of the such licenses, permits or authorizations. Moreover, all personnel employed by or contracted with Delegated Entity who are responsible for providing Delegated Entity' Services to Members are and shall remain throughout the term of this Agreement

appropriately supervised (when and as required by Applicable Law or Government Sponsor), and qualified by education, training and experience to perform their professional duties.

c. This Agreement has been executed by its duly authorized representative. Execution and performance of this Agreement (i) will not violate or infringe upon the rights of any third party, including without limitation confidentiality or privacy rights, publicity rights, or intellectual property rights; and (ii) will not conflict with or violate any commitment, agreement, or understanding Delegated Entity has or will have with any person or entity.

d. It does and shall at all times meet or exceed: (i) all Company and Government Sponsor standards, policies and procedures; and (ii) the standards of NCQA (and is accredited by NCQA) and/or any applicable accrediting organization agreed upon by the parties. In the event that Company or an accrediting organization's standards or any Federal or state statutory or regulatory provisions are materially changed or revised, Delegated Entity agrees to comply with or implement, as applicable, and to the reasonable satisfaction of Company, any such change or revision within such time frame as may be required by the accrediting organization, applicable law or regulation, or if no time frame is stated, within sixty (60) calendar days of receiving notice of such change. The parties agree that any such change or revision shall not be considered an amendment for the purpose of this Agreement.

e. It acknowledges that Company is an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Delegated Entity, Delegated Entity agrees to comply with the following, as amended from time to time: Executive Order 11246, Title VI of the Civil Rights Act of 1964 the Vietnam Era Veterans Readjustment Act of 1974, the Age Discrimination Act of 1975, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, 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, 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 (32 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act), any similar legislation regarding transactions relating to any government contract of Company or an Affiliate, and any rules and regulations promulgated under such laws.

f. Neither Delegated Entity nor any of Delegated Entity's Related Parties who are and/or will be fully or partially responsible for Delegated Entity'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; (ii) been excluded from participation in any federal or state funded health program; or (iii) been listed in the National Practitioner Data Bank ("NPDB") or the Healthcare Integrity and Protection Data Bank ("HIPDB"). If the Delegated Entity or any of Delegated Entity's Related Parties is listed in a either NPDB or HIPDB after the Effective Date, Company shall have the right, in its sole discretion and judgment, to terminate the Agreement as provided in Section 10.4 herein or to disqualify the listed person(s) from providing any part of the Services.

3.2 Incentives. Delegated Entity further represents and warrants that as of the Effective Date, and Delegated Entity covenants that, throughout the term of the Agreement that (a) compensation to persons performing Patient Management under this Agreement shall not contain incentives or remuneration, direct or indirect, in cash or in-kind, to those persons to make inappropriate Patient Management or utilization review decisions that result in underutilization; and (b) compensation or remuneration to persons performing Patient Management under this Agreement shall not be based, directly or indirectly, on the quantity, frequency or percentage of or in any way relating to denials.

3.3 Government Programs. Delegated Entity agrees that all services and other activities performed by Delegated Entity under this Agreement with regard to Medicare Members will be consistent and comply with Company's obligations under its contracts with CMS to offer Plans to Medicare beneficiaries ("Medicare Plans"). Company shall provide such obligations to Delegated Entity at least sixty (60) days prior to the

Effective Date of this Agreement and thereafter upon receiving notice of any change thereto. Delegated Entity shall not be required to comply with Company's obligations under its contracts with CMS unless and until Company provides such obligations to Delegated Entity. Company shall also identify to Delegated Entity those Members enrolled in Medicare or Medicaid Plans. Delegated Entity acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors, and subcontractors of the Delegated Entity who provide or may provide services under this Agreement with respect to Medicare Plans, and Delegated Entity represents and warrants that Delegated Entity shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply with this Agreement and all Applicable Law. With respect to Medicare Plans, Delegated Entity agrees to allow CMS and Company to monitor Delegated Entity's performance under this Agreement on an ongoing basis as described in this Agreement and as required under Applicable Law. Delegated Entity agrees to comply with all Applicable Law, including, without limitation all Medicare laws, rules and regulations, reasonable Company policies and procedures and requirements designed to ensure Company's compliance with such laws, rules and regulations, and all Applicable Law relating to the protection of Medicare Member privacy and confidentiality the accuracy of Medicare Member health records (including, if applicable, the provisions set forth at 42 C.F.R. § 423.136). Company shall provide to Delegated Entity such policies, procedures and requirements at least sixty (60) calendar days prior to the Effective Date of this Agreement, and shall notify Delegated Entity at least fifteen (15) business days before implementation of a change to such. In the event that Delegated Entity reasonably does not or cannot agree to any requirement of the policies and procedures, Delegated Entity may terminate the Agreement with at least ninety (90) calendar days notice to Company. Delegated Entity shall not be required to comply with Company's policies, procedures and requirements unless and until Company provides such policies, procedures and requirements to Delegated Entity. In accordance with this Agreement and as required under Applicable Law, Delegated Entity shall immediately provide to Company any information required by Company to meet its reporting obligations to CMS. Delegated Entity acknowledges that Company may only delegate activities or functions to Delegated Entity in a manner consistent with Applicable Law. Delegated Entity acknowledges and agrees that any of Company's activities or responsibilities under Company's contracts with CMS to offer Medicare Plans that are delegated by Company to Delegated Entity may be revoked in accordance with this Agreement and as required under Applicable Law if CMS or Company determines that Delegated Entity has not performed satisfactorily. With respect to Medicare and Medicaid Plans, Delegated Entity acknowledges that compensation for performing Patient Management and other services described in this Agreement constitutes receipt of Federal funds.

3.3.1 Government Requirements Regarding Records for Medicare Plans. In addition to the requirements of Section 3.8 of this Agreement, with respect to Medicare Plans, Delegated Entity agrees to maintain Information and Records (as those terms are defined in Section 3.8 of this Agreement) 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 designees complete an audit, or (iii) the period required by Applicable Law. In addition to the requirements of Section 3.8 Delegated Entity 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 3.3.1 shall survive the termination of this Agreement, regardless of the cause of termination.

3.4 Hold Harmless. In no event, including without limitation, non-payment by Company, insolvency of Company, or breach of this Agreement, shall Delegated Entity bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Managed Member or persons (other than Company) acting on a Managed Member's behalf for services covered under this Agreement. Delegated Entity further agrees that: (a) this provision shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Managed Members, and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Delegated Entity and a Managed Member or persons acting on a Managed Member's behalf. No

modification of this provision shall be effective without the prior written approval of the appropriate regulatory entities.

3.5 Intentionally Omitted

3.6 Notification of Adverse Action. Delegated Entity shall notify Company promptly after becoming aware of: (i) any material litigation brought against Delegated Entity related to Delegated Entity Services; (ii) any material litigation brought against Delegated Entity related to services similar to Delegated Entity Services provided by Delegated Entity to other persons or entities; (iii) any material actions taken by any government agency involving Delegated Entity or any entity in which Delegated Entity holds more than a five percent (5%) interest; (iv) a five percent (5%) ownership interest with another health maintenance organization or managed care organization; (v) any legal actions or investigations, or notice thereof, initiated against Delegated Entity by governmental agencies or individuals regarding fraud, abuse, false claims, or kickbacks; or (vi) the listing of Delegated Entity or any of Delegated Entity' Related Parties in the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank. Upon Company's request, Delegated Entity agrees to provide all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations, or listings related to Delegated Entity Services to Company.

3.7 Quality Assurance. Delegated Entity represents and warrants that it has established an ongoing quality assurance/assessment program that includes without limitation credentialing of its employees and contractors, as applicable. Delegated Entity shall supply to Company the relevant documentation, including without limitation internal quality assurance/assessment protocols, upon Company's request.

3.8 Information and Records.

3.8.1 Maintenance of Information and Records. In addition to the obligations set forth in Section 3.3.1 above, Delegated Entity agrees (a) to maintain data and information obtained, created or collected by Delegated Entity related to Members ("Information") and books, records and other papers and information relating to this Agreement and Delegated Entity Services ("Records") in a current, detailed, organized and comprehensive manner and in accordance with 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; and (c) to maintain such Information and Records for the period required by applicable law. This Section 3.8.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

3.9 Insurance. Delegated Entity at its sole cost and expense shall procure and maintain such policies of general and professional liability and other insurance as shall be necessary to insure it and its Related Parties against any claim or claims for damages arising directly or indirectly in connection with the performance of Delegated Entity Services under this Agreement. During the entire term of the Agreement, Delegated Entity shall maintain such insurance at minimum levels required from time to time by Company, but in no event less than: (a) comprehensive general liability insurance, at a minimum level of $1,000,000 per claim/$2,000,000 annual aggregate; (b) director and officer liability coverage for Delegated Entity' directors, officers, trustees and managers, at a minimum level of $5,000,000; (c) excess or umbrella insurance for specified medical professions, at a minimum level of $5,000,000 per claim/$10,000,000 annual aggregate; worker's compensation and employer's liability insurance, at such levels as may be required by Applicable Law. Such insurance coverage shall cover the acts and omissions of Delegated Entity as well as those of any of Delegated Entity' Related Parties. Certificates of Insurance evidencing such policies shall be delivered to Company upon request. Delegated Entity shall provide to Company at least thirty (30) days advance written notice of any cancellation or material modification of said policies. Delegated Entity's obligations under this Section may be satisfied through self-insurance arrangements with prior approval by Company of such self-insurance.

4.0 Company Obligations and Representations

4.1 Audit Activities. If Company reasonably believes that Delegated Entity has failed to carry out the Delegated Entity Services in accordance with the terms of this Agreement or Company's reasonable performance expectations, Company may:

a. Audit Delegated Entity's performance of the Delegated Entity Services, upon advance notice or as otherwise provided herein.

b. Require Delegated Entity to submit, within a mutually agreed upon specified time frame, but in no event longer than thirty (30) days, a corrective action plan to address any compliance or other problems identified by Company.

c. Require Delegated Entity to implement, within a reasonable time of notice, but in no event longer than sixty (60) days, a corrective action plan approved by Company and permit increased audits of Delegated Entity's performance to ensure compliance with such plan.

4.2 Company Representations. Company represents and warrants that: (a) Company, 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) Company will not lose such License involuntarily during the course of this Agreement; (c) Company 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 limitations, any applicable prompt payment statutes and regulations or capital reserve requirements; provided however, that for the purposes of (b) and (c), Delegated Entity 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 obligation hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

4.3 Communications

Company shall promptly make available to Delegated Entity such Company policies and other information as are required by this Agreement or reasonably necessary for Delegated Entity to perform the Delegated Entity Services; and shall inform Delegated Entity in writing of significant changes in this information by letter, electronic mail, or other media. Such written notice shall be at least 60 days prior to the implementation of the new or changed standard, policy, procedure or other information, or within such time frame as may be required by the NCQA, URAC or applicable law or regulation. In addition, Company shall work cooperatively with Delegated Entity to continuously improve the Delegated Entity Services and Company's relationship with Delegated Entity.

4.4 Payments and Taxes

4.4.1 Company shall pay Delegated Entity according to the terms set forth in Exhibit 2 (the "Compensation"). In no event shall Company be liable to Delegated Entity for any fees, costs, or expenses, other than those expressly set forth in Exhibit 2 or otherwise contemplated herein, unless, on a case-by-case basis the Company's and Delegated Entity agree in advance and in writing that Company will pay Delegated Entity for additional fees, costs, or expenses.

4.4.2 Delegated Entity acknowledges and agrees that it alone shall be responsible to collect and liable to pay any and all federal, state, local, use, excise, or other tax liabilities resulting from Delegated Entity's performance of its obligations under this Agreement. Delegated Entity shall maintain true and correct copies of records of these tax liabilities and Delegated Entity' payments for a period of ten (10) years following the expiration of the applicable period to which such tax liabilities relate. Notwithstanding the foregoing, if a jurisdiction imposes a new tax that may materially impact this Agreement, the parties will negotiate in good faith the relative responsibilities of the parties for such new taxes.

4.5 Savings Clause

Company's failure to perform any of its responsibilities set forth in this Agreement (other than as set forth in Sections 4.5, 4.7 and Exhibit 2) shall not be deemed to be grounds for termination by Delegated Entity; provided, however, that Delegated Entity' non-performance of any of its obligations shall be excused if and to the extent (i) such Delegated Entity nonperformance results from Company's nonperformance; and (ii) Delegated Entity provides Company with reasonable written Notice of Company's nonperformance and uses commercially reasonable efforts to perform notwithstanding Company's failure to perform.

4.6 Required Data

Company will provide Delegated Entity with all necessary data in the manner that allows it to independently calculate and verify any and all Performance Measures outlined in Exhibit 2. Company agrees and understands that Delegated Entity's ability to successfully perform its duties and obligations under this Agreement are subject to and conditioned on the timely receipt such data.

4.7 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 claims or claims for damages arising by reason of personal injury or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans. Company, at its sole cost and expense shall procure and maintain such policies of general and professional liability and other insurance as shall be necessary to insure it and its Related Parties against any claim or claims for damages arising directly or indirectly in connection with its performance under this Agreement. During the entire term of the Agreement, Company shall maintain such insurance at minimum levels no less than: (a) comprehensive general liability insurance, at a minimum level of $1,000,000 per claim/$3,000,000 annual aggregate; (b) director and officer liability coverage for Company's directors, officers, trustees and managers, at a minimum level of $5,000,000; and (d) worker's compensation and employer's liability insurance, at such levels as may be required by Applicable Law. Such insurance coverage shall cover the acts and omissions of Company as well as those of any of Company's Related Parties. Company's obligations under this section may be satisfied through self-insurance arrangements. Company shall provide to Delegated Entity at least thirty (30) days advance written notice of any cancellation or material modification of said policies.

4.8 Final Determinations. Notwithstanding anything to the contrary contained in this Agreement or any Attachment hereto, Company shall retain the right to make final determinations of appeals of Delegated Entity Patient Management decisions pursuant to the Company's Patient Management program.

4.9 Provision of Relevant Information. Company shall furnish to Delegated Entity information received by Company, including but not limited to Member surveys or complaints, which is relevant, as determined by Company, to the Services provided under this Agreement.

5.0 Relationship of the Parties

5.1 Independent Contractors. Nothing in this Agreement shall be construed to create a joint venture or partnership between the parties. Delegated Entity shall act solely as an independent contractor and not as an agent, servant, employee, or representative of Company or any related entity. Consequently, neither party will have, and neither will make any statement or take any action that might cause any third party to believe it has, the authority to transact any business, enter into any agreement, or in any way bind or make any commitment on behalf of the other or any related entity unless expressly authorized in writing by a duly authorized officer of the other.

5.2 Interference With Contractual Relations.

Delegated Entity shall not: (i) counsel or advise, directly or indirectly, Payors, Plan Sponsors or other entities currently under contract with Company or any Affiliate to cancel, modify, or not renew said contracts; (ii) impede or otherwise interfere with negotiations which Company or an Affiliate is conducting for the provision of health insurance or creation or maintenance of Plans; (iii) use or disclose to any third party Company's membership lists or provider directories or other Member or Provider information, acquired during the term of this Agreement, for the purpose of directly or indirectly soliciting individuals who were or are Members or Providers or otherwise to directly compete with Company or any Affiliate. Nothing in this Section 5.2 is intended or shall be deemed to restrict any communication between Delegated Entity and a Member, or a party designated by the Member, determined by Delegated Entity to be necessary or appropriate in providing Delegated Entity Services.

Company shall not (i) counsel or advise, directly or indirectly, Customers or potential customers of Delegated Entity to cancel, modify, not renew, or not enter into contracts with Delegated Entity; (ii) impede or otherwise interfere with negotiations which Delegated Entity is conducting regarding provision of managed radiological services; and (iii) use or disclose to any third party information acquired during the term of this Agreement for the purposes detrimental to Delegated Entity.

5.3 Non-Solicitation. In no event shall either party directly solicit, recruit, advise or encourage any employee to terminate employment or other relationship with the other party without specific written authorization from the other party. This Section 5.3 does not prohibit and shall not be interpreted to prohibit or otherwise apply to general solicitations by each party (including but not limited to job postings or general announcements regarding position openings) to which an employee responds.

6.0 Confidentiality and Non-Disclosure

6.1 As used herein, a party disclosing Confidential Information is referred to as the "Disclosing Party" and a party receiving Confidential Information is referred to as the "Receiving Party."

6.2 As used herein, "Confidential Information" includes (i) information the Receiving Party knows or reasonably should know would, if disclosed, reveal otherwise proprietary details of the Disclosing Party's provider network(s), policies, procedures, and/or information technology systems and processes; (ii) the terms of this Agreement, including any Exhibits; and (iii) any other information that the Disclosing Party designates in writing as Confidential. "Confidential Information" also includes any reports, notes, summaries, abstracts, distillations, excerpts, work product, or other documents utilizing or incorporating Confidential Information whether in whole or in part; and oral presentations or discussions referring to, describing, elaborating upon, or otherwise relating to Confidential Information.

6.3 The Disclosing Party's information shall not be deemed Confidential Information if (i) it is already, or otherwise becomes known to the general public other than as a direct or indirect result of any act or omission of the Receiving Party or its Related Parties; (ii) it is lawfully received by the Receiving Party from a third party who the Receiving Party verifies has the right to disseminate such information without restriction on disclosure; (iii) it is known to the Receiving Party prior to the date of this Agreement; or (iv) the Receiving Party develops it independently, without use of Confidential Information.

6.4 The Receiving Party acknowledges that it will receive Confidential Information in confidence and solely for its use in performing its obligations under this Agreement. Accordingly, the Receiving Party warrants that it will apply commercially reasonable safeguards to protect the Disclosing Party's Confidential Information against unlawful or otherwise unauthorized access, use and disclosure. The Receiving Party further agrees (i) to permit access to, use, and disclose the Confidential Information solely for the purpose(s) expressly set forth in, and in accordance with, the terms of this Agreement; (ii) not to record, copy, or reproduce any Confidential Information in any form, except to the extent necessary to exercise its rights or fulfill its obligations under this Agreement; (iii) to limit access, use and disclosure of Confidential Information to those of the Receiving Party's employees and agents and to the Receiving Party's Related Parties who are

necessary for and directly involved in the Receiving Party's exercise of its rights or performance of its obligations under this Agreement and to refrain from disclosing or otherwise permitting any third person or entity access to any Confidential Information except with the Disclosing Party's prior written consent; (iv) to ensure that any of the Receiving Party's Related Parties who receive or obtain Confidential Information are advised of the nature of the Confidential Information and of the obligations the Receiving Party has undertaken with respect to such information under the Agreement and agree to comply with these obligations; and (v) to take any other steps reasonably necessary to safeguard Confidential Information against unlawful and otherwise unauthorized access, use and disclosure. The Receiving Party shall provide prompt notice to the Disclosing Party of any breach of the provisions of this Section 6.

6.5 The Receiving Party acknowledges that unauthorized access to, use, or disclosure of Confidential Information may cause irreparable harm and significant injury to the Disclosing Party which will be difficult to measure with certainty or to compensate through money damages. Accordingly, the Receiving Party agrees that injunctive or other equitable relief may be appropriate in the event of any breach or threatened breach by the Receiving Party of any part or parts of this Section 6, in addition to such other remedies as may be available at law. The Receiving Party shall not oppose the granting of such equitable relief.

6.6 The Receiving Party may disclose Confidential Information if required to do so under any Applicable Law; provided, however, that the Receiving Party provides the Disclosing Party with prompt notice of any request for such a disclosure, so that the Disclosing Party may object to the request and/or seek an appropriate protective order or, if such notice is prohibited by law, the Receiving Party shall disclose the minimum amount of Confidential Information required to be disclosed under the applicable legal mandate. In addition, Company may disclose Confidential Information to a Payor or Plan Sponsor if required to do so under any applicable services agreement with such Payor or Plan Sponsor. Except as expressly provided herein, in no event shall the Receiving Party disclose the Disclosing Party's Confidential Information to a party other than a government agency except under a valid order from a court or administrative agency with jurisdiction requiring the specific disclosure.

6.7 Delegated Entity acknowledges that Delegated Entity may receive, in connection with its performance of Delegated Entity Services, certain demographic and other information concerning Members, to facilitate Delegated Entity's performance of Delegated Entity Services, including without limitation information concerning the healthcare provided to such Members and their conditions. Delegated Entity further acknowledges that such information may be Protected Health Information and agrees that in the event the information is Protected Health Information, the provisions of the Section 7 below apply.

7.0 Confidentiality of Member Information, HIPAA and GLBA Compliance

7.1 Confidentiality. Delegated Entity and Company agree that Member Confidential Information must be safeguarded. Delegated Entity agrees to ensure that any information related to a Member is to be kept strictly confidential in accordance with all Federal and state laws regarding, among other things, the confidentiality of patient records and shall not be released to any third party except as set forth in this Section 7. Where allowed by Applicable Law, Company shall be able to obtain Member Confidential Information from Delegated Entity 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 Delegated Entity is, and will be, a "business associate" of Company for purposes of HIPAA and a "service provider" for the purpose of GLBA because of the delegated functions it is performing on behalf of Company.

7.2 HIPAA and GLBA Definitions. For purposes of Sections 7.2 through 7.8 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. Plan Sponsor Information. "Plan Sponsor Information" means nonpublic personal financial and health information about a customer, whether in paper, electronic, or other form. Plan Sponsor 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 Delegated Entity 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 Plan Sponsor 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.

7.3 Obligations and Activities of Delegated Entity.

a. Delegated Entity agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as required by law. Delegated Entity shall also comply with any further limitations on uses and disclosures reasonably agreed to by Company in accordance with 45 C.F.R. 164.522 provided that such agreed upon limitations have been communicated to Delegated Entity according with Section 7.5.1.c of this Agreement.

b. Delegated Entity agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Delegated Entity agrees to mitigate, to the extent practicable, any harmful effect that is known to Delegated Entity of a use or disclosure of Protected Health Information by Delegated Entity in violation of the requirements of this Agreement.

d. Delegated Entity 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. Delegated Entity agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Delegated Entity on behalf of Company agrees to the same restrictions and conditions that apply through this Agreement to Delegated Entity with respect to such information. In no event shall Delegated Entity, without Company's prior written approval (which consent will not be unreasonably withheld), provide Protected Health Information received from, or created or received by Delegated Entity 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. Delegated Entity 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. If Delegated Entity 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. Delegated Entity 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. Delegated Entity shall not charge any fee for fulfilling requests for amendments.

h. Delegated Entity 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 Delegated Entity 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. Delegated Entity 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. Delegated Entity agrees to provide to Company, in the time and manner designated by Company, the information collected in accordance with Section 7.3i 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. Delegated Entity 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, Delegated Entity 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, Delegated Entity 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. Delegated Entity shall report to Company any Security Incident of which it becomes aware.

o. If Delegated Entity conducts any Standard Transactions on behalf of Company, Delegated Entity shall comply with the applicable requirements of 45 C.F.R. Part 162.

p. The parties acknowledge that the services delegated under this Agreement are subject to regulation by applicable federal and state laws and regulations. If Delegated Entity does not or is not able to fulfill any or all of its obligations under this Agreement and Company is subject to any fines or fees from a regulatory agency as a result thereof, Delegated Entity agrees to pay to Company the amount of such fines and any penalties incurred, including any applicable interest. Company shall have sole discretion to pay such fees, fines or penalties or to settle or compromise with such regulatory agencies.

7.4 Permitted Uses and Disclosures by Delegated Entity

7.4.1 General Use and Disclosure. Except as otherwise limited in this Agreement, Delegated Entity 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.

7.4.2 Specific Use and Disclosure Provisions.

a. Except as otherwise limited in this Agreement, Delegated Entity may use Protected Health Information for the proper management and administration of the Delegated Entity or to carry out the legal responsibilities of the Delegated Entity.

b. Except as otherwise limited in this Agreement, Delegated Entity may disclose Protected Health Information for the proper management and administration of the Delegated Entity, provided that disclosures are allowed by law, or Delegated Entity obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as allowed by law or for the purpose for which it was disclosed to the person, and the person notifies the Delegated Entity 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, Delegated Entity 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. Delegated Entity 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).

7.5 Obligations of Company With Respect to HIPAA.

7.5.1 Provisions for Company to Inform Delegated Entity of Privacy Practices and Restrictions

a. Company shall notify Delegated Entity 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 Delegated Entity's use or disclosure of Protected Health Information.

b. Company shall provide Delegated Entity with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes affect Delegated Entity's use or disclosure of Protected Health Information.

c. Company shall notify Delegated Entity 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 Delegated Entity's use or disclosure of Protected Health Information.

d. Company shall not agree to any limitation(s) on use or disclosure of Protected Health Information requested by an Individual that would materially adversely impact Delegated Entity Services.

7.5.2 Permissible Requests by Company. Except as may be set further in Section 7.4.2, Company shall not request Delegated Entity 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.

7.6 Obligations of Delegated Entity With Respect to GLBA.

a. Delegated Entity agrees to implement a comprehensive written information security program that includes administrative, technical and physical safeguards for the protection of Plan Sponsor Information that are appropriate to Delegated Entity's size, complexity, nature and scope of activities, and that is designed to:

(i) ensure the integrity and confidentiality of Plan Sponsor Information;
(ii) protect against any anticipated threats or hazards to the security or integrity of Plan Sponsor Information; and
(iii) protect against unauthorized access to, or use of, Plan Sponsor Information that could result in substantial harm or inconvenience to any customer.

b. Delegated Entity agrees to ensure that any agent, including a subcontractor, to whom it provides Plan Sponsor Information received from, or created or received by Delegated Entity on behalf of Company, agrees to the same restrictions and conditions that apply through this Agreement to Delegated Entity with respect to such Plan Sponsor Information.

c. In no event shall Delegated Entity, without Company's prior written approval, provide Plan Sponsor Information (received from, or created or received by Delegated Entity 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 Plan Sponsor Information outside of the United States.

d. Delegated Entity agrees to make policies, procedures, and documentation relating to the safeguarding of Plan Sponsor 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. Delegated Entity agrees to affirm in writing, upon request from Company from time to time, Delegated Entity's continued compliance with its obligations under this Agreement.

7.7. 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.

7.8 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 Plan Sponsor 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 of the parties may terminate the Agreement on thirty (30) days written notice to the other party.

7.9 Interpretation. Any ambiguity in this Section 7 shall be resolved to permit Company to comply with the Privacy and Security Rules. In the event of any inconsistency or conflict between this Section 7 and any other agreement between the parties, the terms, provisions and conditions of this Section 7 shall govern and control.

8.0 Ownership/Right to Use Materials

8.1 Proprietary Information – Rights and Responsibilities. Subject to Section 8.5 below, 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, Plan Sponsors, 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 and this Agreement, 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 8 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

8.2 Return of Proprietary Information. Upon expiration or termination of this Agreement, the Parties agree either to voluntarily surrender to the other Party all Information in the Party's possession, custody, or control (including without limitation the possession, custody, or control of any Related Parties), or, if the return of such Proprietary Information is infeasible, destroy the Proprietary Information or keep such information confidential. This provision shall survive termination of the Agreement.

8.3 Company Materials. Company shall own all right, title and interest in and to any and all information, documents, inventions, modifications and improvements, including without limitation any drafts, copies and other non-originals or derivatives, developed by Company and/or its Related Parties (other than Delegated Entity), whether transmitted or made available to Delegated Entity by Company or otherwise created or developed by Company in the course of performance under this Agreement (collectively, the "Company Materials").

8.4 Delegated Entity Materials. Delegated Entity shall own all right, title and interest in and to any and all information, documents, inventions, modifications and improvements, including without limitation any drafts, copies, and other non-originals or derivatives, in whole or in part, developed by Designated Entity and/or its Related Parties (other than Company), whether transmitted or made available to Company by Delegated Entity or otherwise created or developed by Delegated Entity in or otherwise as a result of Delegated Entity' performance under this Agreement (collectively "Delegated Entity Materials").

8.5 Acknowledgements. The term "Company Materials" shall not include information, documents, inventions, or improvements created by Delegated Entity prior to the Effective Date or independent of this Agreement (collectively the "Delegated Entity Materials"). Company acknowledges and agrees that the Delegated Entity Materials include, without limitation:

8.5.1 Computer member record ("CPR"), AIM technology which creates customized interventions for Members based on deviations from standards of care ("AIM"), predictive radiology intelligence ("PRI"), and interactive voice response ("IVR") technology, equipment, system, and software; provided, however, that nothing herein shall be deemed to transfer to Delegated Entity ownership of any patient records.

8.5.2 Additions and/or modifications to the CPR, AIM and/or IVR technology and any other technology used by Delegated Entity in providing Delegated Entity Services.

For avoidance of doubt, the parties acknowledge and agree that: (a) all inventions, improvements, discoveries, developments, techniques, processes, research and development plans and results, reports, drawings, designs, schematics, databases, specifications, works of authorship, data, formulas, files, HTML, computer source and object code, patent applications, and any other materials and creations (and any related improvements or modifications to the foregoing) (collectively, "Creations") that are developed or created by a party shall be exclusively owned by such party, and (b) no Creations shall be deemed jointly owned by the parties unless prior to the development of such Creation the parties agree in writing to jointly own such Creation, including the terms and conditions relating to each party's rights, obligations and restrictions on use and exploitation of such jointly owned Creation.

8.6 Return of Materials. Upon Delegated Entity' request after expiration or termination of this Agreement, subject to Sections 2.5, 3.8 and 6 of this Agreement: (a) Company shall return any Delegated Entity Materials in its possession to Delegated Entity, and (b) Delegated Entity shall return any Company Materials in its possession to Company.

8.7 Reservation of Rights. The parties acknowledge and agree that each party claims and reserves all rights afforded to it under all applicable intellectual property laws in all of its information, including without limitation Confidential Information, Company Materials and Delegated Entity Materials. The Agreement shall not affect any transfer of right, title, or interest in or to any such information, and each party agrees that it shall not assert any right, title, or interest in or to the other's Confidential Information, Company Materials or Delegated Entity Materials, as applicable. Nothing herein shall be deemed to preclude Delegated Entity from maintaining, using, or disclosing Member information obtained from Company to perform its obligations under this Agreement or to exercise its rights under Section 4.1 and 4.2 herein; nor shall anything herein be deemed to preclude Company from maintaining, using, or disclosing Member information obtained from Delegated Entity in issuing, servicing, or administering any Plan(s).

9.0 Indemnification

9.1 Subject to Section 9.3 herein, Delegated Entity shall indemnify, defend and hold Company and Company's Related Parties harmless from any actual legal or administrative action, claims, liability, penalty, fine, assessment, lawsuit, litigation, or other loss, expenses, or damage, including without limitation any reasonable attorney's fees and costs (together "Liability"), that Company or Company's Related Parties may incur as a result of: (i) any acts or omissions of Delegated Entity or any of Delegated Entity's Related Parties related to the provision of the Delegated Entity Services or failure to provide such Delegated Entity Services; or (ii) the receipt, maintenance, use or disclosure by Delegated Entity or any of Delegated Entity's Related Parties of any Confidential Information in a manner that is not authorized by this Agreement and permitted under all applicable laws, regulations, and other legal mandates.

9.2 Subject to Section 9.3 herein, Company shall indemnify, defend and hold Delegated Entity and Delegated Entity 's Related Parties harmless from any Liability that Delegated Entity or Delegated Entity's Related Parties may incur as a result of: (i) any acts or omissions of Company or any of Company's Related Parties related to Company's duties under this Agreement: or (ii) the receipt, maintenance, use or disclosure by Company or any of Company's Related Parties of any Confidential Information in a manner that is not authorized by this Agreement and permitted under all applicable laws, regulations, and other legal mandates. For purposes of clarity, any acts or omissions of Company shall not mean (i) the act of contracting with

Delegated Entity for the Services; or (ii) the fact that Company did not overturn a decision of Delegated Entity.

9.3 Litigation. When either party is seeking indemnification under Sections 9.1 and 9.2 above, Company must notify the other party in writing within 30 days of any actual or threatened action, suit or proceeding to which such party claims indemnification applies. Failure to so notify the other party shall not be deemed a waiver of the right to seek indemnification, unless the actions of such party have been prejudiced by the failure of the party to provide notice within the required time period.

Each party may then take steps to be joined as a party to such proceeding, and the other party shall not oppose any such joinder. Whether or not such joinder takes place, the indemnifying party shall provide the defense with respect to claims to which this Section applies and in doing so shall have the right to control the defense and settlement with respect to such claims, provided however, with respect to any settlement, the other party shall have the right to consent to such settlement, which consent shall not be unreasonably withheld.

Either party may assume responsibility for the direction of its own defense at any time, including the right to settle or compromise any claim against it without the consent of the other party, provided that in doing so it shall be deemed to have waived its right to indemnification except in cases where the other party has declined to defend against the claim.

10.0 Term/Termination

10.1 Term. This Agreement shall be effective for an initial term of three (3) years ("Initial Term") from its Effective Date and thereafter shall automatically renew for additional one year terms, unless and until terminated in accordance with this Section 10. Upon commencement of this Agreement, all prior agreements, between the parties, for the same or similar services shall terminate.

10.2 Termination for Convenience. This Agreement may be terminated without cause by either party upon written notice to the other party, as follows: i) By Delegated Entity or Company, upon 180 days' notice to be effective no earlier than the conclusion of the Initial Term; or ii) by a Third Party Affiliate, upon 90 days' notice by Company or the owners of such Third Party Affiliate, as to such Third Party Affiliate, after the first anniversary of the commencement of services for such Third Party Affiliate. Company may exercise its rights hereunder as to a one or more specific affiliates, in which case the Agreement between Company and Delegated Entity with respect to Company and all other Affiliates shall remain in full force and effect.

10.4 Program Effectiveness Termination. This Agreement may be terminated by Company, as to any Affiliate, after the first anniversary of the commencement of services for such Affiliate in the event that Company or any Affiliate has determined in its reasonable discretion that the Program is not meeting the effectiveness that the parties intended in increasing adherence to evidenced- based guidelines. Such termination shall apply solely to the relationship between that Affiliate and Delegated Entity. The Agreement between Company and Delegated Entity with respect to Company and all other Affiliates shall remain in full force and effect.

10.3 Termination for Cause.

10.3.1 This Agreement may be terminated at any time by either party upon at least ninety (90) days' prior written notice of such termination to the other party upon (i) material default or substantial breach by such party of one or more of its obligations hereunder, unless such default or breach is cured within ninety (90) days of the notice of termination or, (ii) Delegated Entity enters into an arrangement whereby Delegated Entity is partially or a wholly owned subsidiary of the following managed care organizations, Centene, Molina, WellCare, United Healthcare, Cigna, WellPoint, Humana or any Blue Cross/Blue Shield Affiliate. Any notice of termination under this provision shall specify the Early Termination Date. In the event that either party breaches any of its

obligations hereunder, the other party shall be entitled to pursue injunctive or any other equitable relief in addition to such other remedies as may be available to the other party at law or under this Agreement.

10.3.2 Certain quantitative and qualitative performance standards for the Delegated Entity Services (the "Performance Guarantees") are set forth in Exhibit 3 of the Agreement, which is attached hereto and incorporated herein by reference. Failure to meet any Performance Guarantee for any Reporting Period, as defined in Exhibit 3, shall not constitute a material breach for the purposes set forth in this Section 10. Nothing herein shall be deemed to prejudice any contractual or other remedies, whether at law or in equity, to which either Party may be entitled for the other Party's non-performance or inadequate performance of its obligations under this Agreement.

10.4 Termination or Suspension Upon Notice. Company may terminate or suspend this Agreement immediately upon written notice to Delegated Entity in the event of: (i) a suspension, withdrawal, expiration, non-renewal, or revocation of Delegated Entity' or Company's applicable licenses, certificates, permits, authorizations, or other legal credentials required by law to perform duties under this Agreement; (ii) the Delegated Entity's conviction, or guilty or no contest plea for a felony or for any criminal charge; (iii) the cancellation, reduction, limitation, or termination of any insurance required under Section 3.9 of this Agreement; (iv) Delegated Entity's suspension or debarment from participation in any government-funded health care or health benefits programs; (iv) a determination by Company that Delegated Entity' performance of Delegated Entity Services could result in harm to Members, provided that Delegated Entity has been provided a one hundred twenty (120) day cure period to rectify any aspect of its service that may cause harm to Members; (v) a declaration by a Party of insolvency or filing in bankruptcy, the appointment of a receiver, the assignment of assets, for the benefit of a Party's creditors, the settlement of outstanding debts of a Party under applicable reorganization or insolvency laws by a Party; (vi) as to a specific Affiliate, the sale of such Affiliate or its cessation of business, or as to a Third-Party Affiliate, the cessation of Company's provision of services to such Third-Party Affiliate; or (vii) a Party's failure to obtain accreditation. Each Party shall provide the other with immediate notice of any of the aforesaid events.

10.5 Obligation to Cooperate. Upon termination of this Agreement for any reason, Delegated Entity agrees to cooperate fully with Company, and comply with Company procedures, if any, in the transfer of Delegated Entity's obligations hereunder to Company. Delegated Entity agrees to promptly provide Company with any and all information and documentation necessary for such transfer.

10.6 Material Breach. Delegated Entity agrees that it shall be a considered a material breach of this Agreement if an action plan agreeable to Company cannot be developed or implemented within thirty (30) business days. If such serious problems cannot be corrected within such time period, Company may assume all or a portion of the Delegated Entity Services upon notice to Delegated Entity. If at such later time Delegated Entity can demonstrate to Company that it is able to meet the requirements of this Agreement, Company, in its sole discretion, may allow Delegated Entity to resume performing the Delegated Entity Services on a date set by Company.

10.7 Obligations During Dispute Resolution Proceedings. In the event of any dispute between the Parties for which a Party may provide notice of termination under Section 10.3, the dispute must first be submitted for resolution under Section 11.0 below. 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.

11.0 Arbitration

11.1 Submission. 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 in Montgomery County, Pennsylvania (the "Locale") administered by the American Arbitration Association ("AAA") and conducted by a sole Arbitrator ("Arbitrator") in accordance with the AAA's Commercial Arbitration Rules ("Ruler"). A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds

$150,000. The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 11-16, 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. An Award for $150,000 or more shall be accompanied by a short statement of the reasoning on which the Award rests.

11.2 Appeal. Within thirty (30) days of receipt of an Award of $150,000 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 Appeal Arbitrator shall not take new testimony or other evidence and shall not modify or replace the Award except for clear error of law. 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.

11.3 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 an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to an arbitration, or reflect the existence, content, records, status, or results of an arbitration, constitutes Confidential Information under and is subject to the provisions of Section 6 of this Agreement. The hearing shall be closed to any person or entity other than the arbitrator, the Parties, and witnesses during their testimony, and attorneys of record. Upon the request of a Party, an arbitrator may taken such actions as are necessary to enforce this Section 11.3, including the imposition of sanctions.

11.4 Prehearing Procedure. 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 of claim, all documents in their possession or control on which they rely in support of their positions or which they intent 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 every effort 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 $150,000, 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 a 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) pre-marked copies of all exhibits they intend to use at the hearing.

11.5 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.

12.0 General Provisions

12.1 Amendments. This Agreement may be amended by mutual agreement of the parties, provided that no amendment shall be effective until it is reduced to writing and signed by an authorized representative of each party. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice to Delegated Entity to comply with applicable law or regulation (including a change in interpretation of any law or regulation) or any order or directive of any governmental agency, which amendment shall promptly be communicated to Delegated Entity in writing. If such amendment to accommodate applicable law or regulation requires a material change to the Services and is not acceptable to Delegated Entity, Delegated Entity may terminate this Agreement upon 120 days written notice or upon the effective date of such amendment.

12.2 Notice. Any written notice permitted or required by this Agreement shall be sent by certified mail, return receipt requested, by overnight dispatch, by hand delivery, or by electronic dispatch combined with one of the above listed means, to the address listed below or to such later address as may be specified in like manner. Notice shall be deemed given upon dispatch.

If to Company: See Exhibit A for each Affiliate's Notice address.	If to Delegated Entity: Chief Customer Officer MedSolutions, Inc. 730 Cool Springs Blvd, Suite 800 Franklin, TN 37067 With a copy to General Counsel MedSolutions, Inc. 730 Cool Springs Blvd, Suite 800 Franklin, TN 37067

12.3 Assignment. This Agreement may be assigned by Company to an Affiliate or a successor in interest, provided that the rights, obligations, and liabilities of Delegated Entity will not be affected by any such assignment. This Agreement may not be assigned or delegated by Delegated Entity without the prior written consent of Company or, if applicable, its successor, consent of which shall not be unreasonably withheld.

12.4 Subcontracting. If, upon consent of Company, Delegated Entity sub-delegates a portion of its duties under this Agreement, Delegated Entity and the sub-delegated entity shall sign an agreement that meets all of the requirements and provisions of this Agreement and, if Company determines necessary, a three-party including Company as a party.

12.5 Waiver. The waiver of any breach of this Agreement will not be deemed to waive any other breach. To be effective, any and all waivers must be in writing, expressly identifying the specific rights or provisions under this Agreement being waived, and signed by the party to be charged.

12.6 Non-Exclusivity. This Agreement is not exclusive and nothing in this Agreement precludes either party from participating in or contracting with any other party for any purpose.

12.7 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. Furthermore, the Parties shall work to reform the offending provision to retain its original intent

while making it acceptable to the applicable court. Notwithstanding the foregoing, this Agreement shall be void where prohibited by applicable law.

12.8 Governing Law. This Agreement shall be governed in all respects by the laws of the State of Delaware provided, however that with respect to each Affiliate, services must be delivered in accordance with the law applicable to the delivery of services in such Affiliate's state.

12.9 Intentionally Omitted.

12.10 No third party beneficiary. Except as otherwise provided herein, 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 or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

12.11 Remedies. Notwithstanding Section 11.0, 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) 7 and 8.

12.12 Force Majuere. 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 12.12 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.

12.13 Survival. In addition to those previous provisions which by their terms survive expiration or termination of this Agreement, 2.5.3, 2.5.4, 3.8, 7, 8.2, 11, 12.8, and 12.11 shall survive expiration or termination of this Agreement, regardless of the cause giving rise thereto.

12.14 Headings. The headings in this Agreement are included for purposes of convenience only, and shall not effect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

12.15 Entire Agreement. This Agreement is the entire agreement among the parties with respect to the subject matter hereof and supersedes any and all previous agreements whether written or oral with respect to such subject matter. However, nothing in this Agreement shall affect the rights and obligations of the parties under any other agreement or contract among or between them now existing or hereinafter executed, except as expressly provided herein.

12.16 Affiliates. The signature herein authorizes Company to sub delegate specific services to Delegated Entity. Affiliates listed in Exhibit B shall maintain authority to direct Company to conduct regular business activities including on their behalf. The Agreement may be amended and signed by Company without the need for additional signatures from Affiliates.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date.

MEDSOLUTIONS, INC.

By: _____
(Signature)

Printed Name: Allan D. Poenitske

Title: Sr. VP, Financial Operations

Date: 12/16/13

Tax I.D. Number: 62-1615395

AETNA MEDICAID ADMINISTRATORS LLC

By: _____
(Signature)

Printed Name: Debra J. Bacon

Title: CFO and Treasurer

Date: January 7, 2014

Exhibit 1

Description of Delegated Entity Services

This Exhibit shall be governed by and construed in accordance with the terms and conditions of the Radiology Management Services Agreement (the "Agreement") entered into by and between Aetna Medicaid Administrators LLC and Delegated Entity. The Parties agree that any changes or revisions in the standards described in this Exhibit or any new standards developed by Company shall be considered an amendment for the purposes of this Agreement. Delegated Entity will provide the Delegated Entity Services as follows:

Radiology Program

The Radiology Program is to promote the most appropriate and effective use of outpatient diagnostic imaging services. Delegated Entity will maintain broad and national or regional access and experience interacting with free-standing radiology network facilities which include the following services: CT/CTA, MRIs/MRAs, Nuclear Medicine and PET and/or PET/CT Fusion (as described in Attachment 1). The program will be administered through strategic solutions including innovative web-based applications, licensed health care professionals applying utilization management and development of preferring imaging networks through a clinical certification process. The program should result in the following benefits:

- Immediate reductions in current radiology spend for unnecessary or inappropriate services
- Utilization management for clinically appropriate and cost-effective use of Diagnostic Imaging Services
- Improved services and quality and customer satisfaction

Delegated Entity will be staffed with experienced clinicians who have access to Company's Clinical Policy Bulletins to apply to Delegated Entity's clinical algorithms in information technologies. This technology will provide an efficient process for provider consultation and for registering procedures according to Company guidelines. Referring physicians or their clinical staffs can receive approval or are notified that the decision has been forwarded for consultation by a board certified radiologist or physician; accessible through telephone, fax or Internet. The application of information systems, clinical support algorithms and telephone-based technologies will enable the Delegated Entity to make denials, peer-to-peer consultations or approvals of the requested imaging studies. Furthermore, the Delegated Entity can further assist physicians or their staff in finding the most cost-effective, quality radiology facility closest to the Managed Member's home.

A. Patient Management Services

1. Patient Management Program

The Delegated Entity agrees to maintain a written Patient Management plan description which includes policies and procedures to evaluate criteria for medical necessity, information sources and processes used to review and approve the provision of services to Managed Members. Delegated Entity's Patient Management Program shall be subject to the oversight of a Board-Certified Physician. These policies and procedures must be consistent with Company policies and procedures and must comply with the accreditation standards of NCQA and URAC (when applicable), as well as statutory and regulatory requirements and contractual obligations. The Delegated Entity's Patient Management plan description should be revised as needed and submitted in writing to Company for review and reasonable approval at least annually, and more often if required by Company in accordance with this Agreement.

Delegated Entity agrees to perform various Patient Management functions identified by Company. Patient Management functions shall include:

a. Patient Management Notification-- precertification of outpatient radiology services;

b. Retrospective review of outpatient radiology services.

Delegated Entity agrees that, except in an Emergency, all services shall be provided through participating Radiology Providers.

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 representative from Company agrees to 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 Clinical Policy Bulletins, which shall be provided in a timely manner to Delegated Entity. 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, in accordance state and federal mandated or such reasonable 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. If, required by applicable law, a Board Certified Physician licensed to practice medicine in the state in which the applicable Member resides (or, if required by law, the state where the Diagnostic Imaging Services requested are to be provided) shall review and approve any recommendation for an Adverse Determination based on medical necessity in advance of communication of the Adverse Determination to a Provider. Delegated Entity agrees to ensure that the reason for any denial is clearly documented, and written in layperson terminology, 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 standards and guidelines. Company will provide ninety (90) days prior written notice of material changes in policies and procedures. If such a change in the policies and procedures to accommodate applicable law or regulation is not acceptable to Delegated Entity, Delegated Entity may terminate this Agreement upon 120 days written notice. 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) business 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.

Delegated Entity shall be solely responsible for preparing and distributing the following types of written communications, in conformance with the terms and conditions of this Agreement and Applicable Law.

- Standard Denial Letters (Provider and Member)
- Retrospective Denial Letters (Providers and Member)
- Lack of Information (Administrative Closure) Letters (Provider and Member)
- Precertification Notifications, as required by applicable law (Provider and Member)
- Retrospective Certificate Notification (Provider and Member)
- Insufficient Information (45 day pend) Letters (Provider and Member)

Company will provide Delegated Entity templates of each of the above communications, as applicable. Any revisions to said templates made by Delegated Entity shall be subject to Company's advance written approval which approval shall not be unreasonably withheld. Delegated Entity acknowledges that Company may require modifications to approved communications templates for regulatory or other reasons and agrees to implement such modifications within thirty (30) days after Company's request or such earlier time as may be required by applicable law. Company acknowledges that Delegated Entity may require modifications to approved communication templates and agrees to work in good faith to cooperate with Delegated Entity to review and approve Delegated Entity requests for modifications within 30 days after Delegated Entity requests.

- In the event Delegated Entity pre certifies a Diagnostic Imaging Services, Delegated Entity shall notify the relevant provider(s) by telephone, fax or electronically within twenty-four (24) hours and shall in all circumstances provide written or electronic confirmation of a telephone notification within state and federally mandated timeframes or within two working days of the precertification; whichever is sooner.
- The Basis for each and every Adverse Determination shall be clearly and completely documented by Delegated Entity in its records and communicated to the applicable Provider(s) verbally and in writing and Member in writing. Each communication of an Adverse Determination shall include at least: (I) the principal reason(s) for the Adverse Determination in layperson terminology and include a specific reference to the Plan provision or clinical guideline upon which the determination was based; (2) instructions for arranging a peer to peer discussion with the Board Certified Physician who approved the Adverse Determination; (3) instructions for requesting a written statement of the clinical rationale for the Adverse Determination, including the Clinical Review Criteria used in making the Adverse Determination; and (4) instructions for appealing the Adverse Determination to Company. Each written notification shall be signed by the Chief Medical Officer or the Board Certified Physician who approved the Adverse Determination.
- Delegated Entity shall grant any provider seeking Precertification or other approval of a Diagnostic Imaging Service the opportunity to request, on an informal basis up to three (3) business days after the denial letter is issued, reconsideration of an initial Adverse Determination, unless specifically prohibited by state law. Such reconsideration shall be performed within one (1)

business day of Delegated Entity's receipt of the request and shall be performed by the Board-Certified Physician who made the Adverse Determination or his or her equally qualified designee. An equally qualified designee may be a non-physician if information is provided in the reconsideration which reasonably meets the Clinical Review Criteria.

- Delegated Entity shall immediately refer all grievances, appeals, and requests for review to Company for final disposition. Delegated Entity shall provide Company any documents or other information required by Company to resolve a grievance or appeal or in connection with an external review proceeding no more than one (1) business day from the date of Company's request, or sooner if required by state mandate or law in the case of an expedited grievance, appeal, or external review proceeding; and no more than five (5) business days from the date of Company's request, in the case of a standard grievance, appeal, or external review proceeding.

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.

6. 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 and any updates or revisions any, as applicable;

b. Annual written evaluation of Patient Management program;

c. Patient Management committee minutes describing Patient Management activity;

d. Quarterly summary report containing data which is mutually agreed upon by the parties, which shall at a minimum include data on admissions, types of care, denials, referrals, utilization measures (including HEDIS Utilization Management measures).

e. 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.

g. Delegated Entity shall provide certain reports of Referring Physicians and Radiology Providers (by Company's assigned Provider ID number), as described in section h (iii) below. Any sampling methodology to be employed by Delegated Entity in preparing the reports shall be subject to the advance written approval of a duly authorized Company representative. The reports shall be based on population averages and, where available, normative data, and shall identify outlier providers. Company may, in its· discretion, share such reports with applicable providers. Delegated Entity

shall not share such reports with any provider or other third party except with the advance, written consent of a duly authorized Company representative. Each Physician Report shall include, without limitation literature supporting the conclusion made in the report (as well as references to any literature that directly or by implication disputes the conclusion); and specific actionable recommendations regarding outlier providers, as may be deemed appropriate by Delegated Entity. Delegated Entity's obligation hereunder is contingent upon Company providing all necessary information as agreed to by the Parties.

h. Reports to Company - Delegated Entity shall compile and deliver to Company the following reports in a format established upon mutual agreement of the Parties:

i. Reports summarizing Precertifications or other approvals of Diagnostic Imaging Services and of all Adverse Determinations issued during the previous day in adequate detail to be used by the Company claim systems for claims payment, not less frequently than daily, unless otherwise agreed by the Parties.

ii. Reports, within one (1) business day, of all (i) complaints (whether written or oral) related in any way to the Services, from or about a Member, Referring Physician, or Radiology Provider; and (ii) attorney contacts concerning any Members, Referring Physicians, or Radiology Providers.

iii. Monthly reports that include, without limitation, information concerning: Phone data records which includes: total number of calls, answer speed, abandon calls, abandon rate percentage and Total Service Factor Precertifications by modality with the following categories of review:

- o Total Number of Requests
- o Adverse Determinations (with percentage)
- o Withdrawal of precertification request o
- o Approved requests (with percentage)
- o Pending requests

Percent of case that meets timeliness of review decisions by category

- o Standard Pre-Service
- o Urgent Pre-Service
- o Medicare Expedited Review
- o Retrospective Review

Detailed reports with requested and approved studies by 'Referring Provider specialty and procedure requested (by procedure code), subject to the limitation of Company providing Referring Provider specialty files in a form reasonably acceptable to Delegated Entity.

Steerage Reports, as mutually developed and agreed upon.

Other reports as required by state or federal mandates

7. Reports from Company.

To the extent applicable to Delegated Entity's performance of PM services, Company shall provide to Delegated Entity the following information in standard electronic format on a monthly basis:

(a) the names and dates of birth or social security numbers of the Members who are eligible or assigned to receive services from Delegated Entity, including the Members added and terminated since the previous reporting period;

(b) the age, sex, benefit plan and any riders to that benefit plan, and employer for the Member who are eligible or assigned to receive services from Delegated Entity;

(c) in the event Company pays any claims that are the financial risk of Delegated Entity, a summary of the number and amount of claims paid by Company on behalf of Delegated Entity during the previous reporting period;

(d) in the event Company pays any claims that are the financial risk of Delegated Entity, a summary of the number and amount of radiology claims paid for each enrollee for which the Delegated Entity has taken partial risk during the previous reporting period;

(e) Member complaint data that relates to Delegated Entity;

8. Surveys

Delegated Entity agrees to conduct regular surveys, no less frequently than annually, involving 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 Participating Provider surveys.

9. Notification of complaints

Delegated Entity agrees to notify Company, within 2 business days of receipt, of any complaints, either oral or written, received by Delegated Entity from Participating Providers and all attorney contacts involving Members. In the case of emergency care, Delegated Entity shall forward the complaint to Company within 24 hours.

10. Scope of Services

(i) The Patient Management services performed by Delegated Entity shall be provided only in connection with procedures identified by Company.

B. Provider Call Management Services

1. Procedures
Delegated Entity agrees to establish procedures to ensure consistent and accurate management of Provider calls.

2. Education
Delegated Entity agrees to provide education to appropriate staff regarding proper call procedures.

3. Toll Free Number
Delegated Entity shall establish and maintain call centers where Participating Providers can call a toll-free number with questions, appeals, and grievances. Delegated Entity agrees to maintain a separate toll-free number specific to Company for use by Members and Providers.

4. Ability to Observe Service
Delegated Entity will provide the capability to record and monitor live calls to ensure compliance with this Agreement, 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 4.1
- Monthly Call Quality reports
- Utilization reports
- Prior Authorization Summary reports
- Requesting physician reports
- Performing facility reports
- CPT detail reports by modality
- Most frequent study requested reports
- Denial reports (administrative and medical necessity)
- Call center reports
- Turnaround time reports (based upon Company requirements
- Complaint reports
- Redirection reports
- Adhoc requests by Company

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 the 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. Operating Hours

   Operating hours will initially be from 8:00am to 8:00pm Eastern time, Monday through Friday. 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.

Exhibit 2: Compensation Schedule

This Compensation Schedule shall be governed by and construed in accordance with the terms and conditions of the Radiology Management Services Agreement (the "Agreement") entered into by and between Aetna Medicaid Administrators LLC and Delegated Entity. The rates described in this Exhibit 2 are payable to Affiliate beginning on the Effective Date listed on the signature pages of Exhibit A.

Administrative Payment Amount.

The Administrative Fees by member type and modality are listed in the following table. The Administrative Fees by state are listed in the tables below.

General Rate Summary.

Modality	TANF	CHIP	ABD	LTSS	Duals	Other	SNP - draft
Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Cardiology	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Ultrasound	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
Ultrasound OB only	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Ultrasound Non-OB	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

- Advanced Imaging includes management of MRI. MRA. CT. CTA and PET
- Cardiology includes management of Nuclear Cardiology. Heart Catherization. Stress Echo. TTE. and TEE)
- Ultrasound includes management of OB and non-OB ultrasound. if the plan's TANF ultrasound utilization is below 150/K the price will be [redacted]

Each month. Delegated Entity shall charge Company an Administrative Fee for the provision of Delegated Entity Program Services. The monthly Administrative Fee shall be equal to the aggregate of the applicable per Member per month amounts set forth in the table below:

State	Modality	TANF	CHIP	ABD	LTSS	Duals	Other
Arizona	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Delaware	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
	Ultrasound - Non OB Only	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
Illinois	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
Maryland	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
	Ultrasound – Full	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
New Jersey	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
New York	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
Ohio	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

Pennsylvania	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
Texas	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
Virginia	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

1) Payment. On or before the 15th day of each month, Company shall prepay Delegated Entity an "Administrative Fee" for provision of Delegated Entity Program services.

a) If a Member is added to Company Membership on or before the 15th day of a month, a full month's Service Fee will be due for that month. There will be no Administrative Fee due for Members added after the 15th day of the month.

b) A full month's Administrative Fee will be due for the month of termination of a Member if the Member terminates after the 15th day of the month. If a Member terminates on or before the 15th day of a month, no Administrative Fee will be due for the month of termination.

2) Adjustments. Where Company due to information delays, must make a retroactive addition or deletion to Delegated Entity's membership records, a retroactive adjustment shall be made concurrent therewith and such retroactive Administrative Fee adjustments shall not exceed sixty (60) days for each single Member. With the exception of any fraud investigation the limit to the period of time in which Delegated Entity or Company can make a claim of an overpayment or underpayment or contest an underpayment or overpayment under this Agreement is one hundred eighty (180) days from the date of the payment was made or one hundred eighty (180) days from the date of final adjudication.

The **Administrative Payment** amounts otherwise due to Delegated Entity shall be reduced as follows for Delegated Entity's failure to meet the Performance Guarantees set forth in Exhibit 3.

1. For failure to meet any of the satisfaction measures set forth in Exhibit 3, Section B.1 for the previous calendar year, [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous year, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

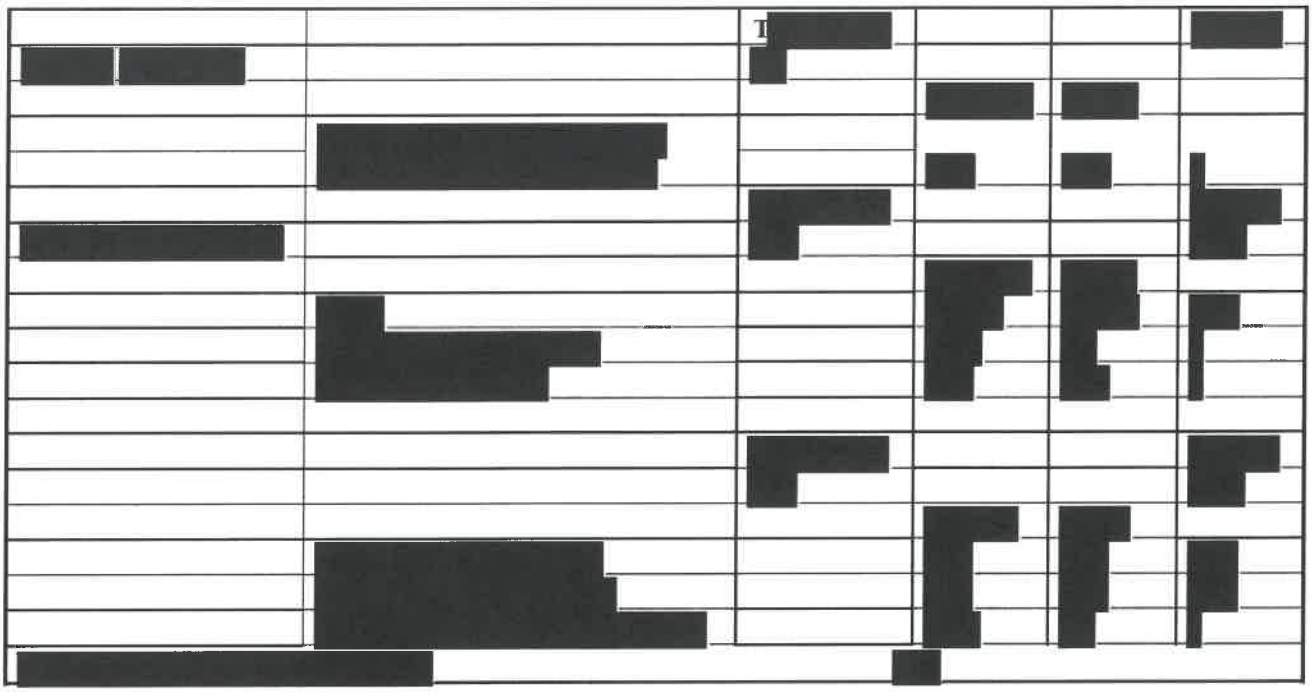
2. For failure to meet any of the call center measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.2: [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous month, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

3. For failure to meet the pre-certification turn-around-time and Adverse Determination overturn measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.3: [redacted] of the annualized Administrative Payment Amounts (excluding the Sleep Administrative Services Fee) payable by Company during the previous quarter, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

4. For failure to meet the pre-certification turn-around-time overturn measures for the Sleep Program when averaged for the calendar year measured as set forth in Exhibit 3, Section B.4: [redacted] of the annualized Sleep Administrative Services Fee payable by Company during the previous quarter,

5. Example

Delegated Entity performance results are measured after the Program Year has been completed. Those results become published ninety (90) days at the completion of the Program Year. The results at end of the Program Year show the following:



6. **Implementation Costs** Delegated Entity shall pay Company the actual costs incurred by Company, but **no more than** [redacted], **towards Company's implementation** costs of the radiology management program ("Implementation Fee"). Delegated Entity shall pay a first installment of [redacted] of the Implementation Fee no later than 15 days after this Agreement's signature. Delegated Entity shall pay second and subsequent installments of the Implementation Fee, if needed, each year thereafter.

Exhibit 3: Performance Guarantees

This Exhibit shall be governed by and construed in accordance with the terms and conditions of the Radiology Management Services Agreement (the "Agreement") entered into by the Parties. Delegated Entity shall comply with the performance guarantees described in this Exhibit 3. If Government Sponsor

or Company requires more stringent standards, Delegated Entity shall comply. Company shall provide Delegated Entity advance notice of any performance standard changes.

A. Definitions

1. Performance Report. A report of the results of a party's measurement of Delegated Entity's performance against a standard described in Section B below (a "Performance Guarantee"). Each Performance Report shall be in a form mutually acceptable to Company and Delegated Entity.

2. Program Year. The one (1) year period following the applicable effective date and each one (1) year period beginning on an anniversary of the effective date. The results of such performance will be made available calculated no later than ninety (90) days at the close of each Program Year.

B. Standards

1. Provider Satisfaction [redacted]
Delegated Entity shall, at Delegated Entity's sole cost and expense, perform one Referring Physician satisfaction survey (the "Physician Survey") and Radiology Provider satisfaction survey (the "Provider Survey") during the third (3rd) or fourth (4th) quarter of each Program Year to measure Delegated Entity's performance against the satisfaction standards set forth below. The Physician Survey and Radiology Survey should contain data collection methodology that produces valid and reliable results. Each survey should be reviewed by Company prior to performing for the following elements:

- Who administered the survey on behalf of Delegated Entity:
- To whom the survey was administered by – physician or office staff;
- How the survey validity was established;
- How the survey was administered;
- How the results were analyzed;
- The definition of a completed survey;
- The expected and achieved response rate; and
- Frequency of re-measurement

The survey shall be performed according to the description in the table below, or as otherwise agreed by the Parties. No more than thirty (30) days following completion of the surveys, and in any event within thirty (30) days after the last date of each Program Year, Delegated Entity shall provide Company with a Performance Report for the survey completed during the previous Program year.

Measure	Description	Standard	Performance Credit
Referring Physician Satisfaction/Radiology Provider Satisfaction Percent of Referring Physicians/Radiology Providers who express satisfaction with the UM Program (based on a 5-point scale).	Population: Referring Physicians who have precertified services during the most recent three (3) months during the applicable Program Year. Radiology Providers who have either precertified or delivered services that received certification from Delegated Entity during the most recent three (3) months during the applicable Program Year. Sample: An appropriate random sample drawn from the Population. Numerator: Of the Referring Physicians/Radiology Providers who respond to the satisfaction survey, the number who rate their satisfaction with the UM Program as "good", "very good", or "excellent". Denominator: All Referring Physicians/Radiology Providers who responded to the satisfaction survey.	[redacted]	[redacted]

2. Call Center Performance Measures [redacted]
Delegated Entity shall utilize its databases and other tools to determine Delegated Entity's compliance against the call center performance standards set forth in the table below or as otherwise required by Company and communicated to Delegated Entity. Delegated Entity shall perform this analysis for each calendar month during each Program year and report the results to Company no later than the tenth (10th) day (or next business day if the tenth day falls on a weekend or legal holiday) of the following calendar month. In the absence of Delegated Entity's capabilities to differentiate between clients for purposes of determining telephone standards, calculations may aggregate like calls received from members, Radiology Providers and referring physicians. The overall results will be a cumulative average for the Program Year.

Measure	Description	Standard	Performance Credit
Average Speed of Answer	The average answer speed for telephone calls placed by Managed Members, Radiology Providers, and Referring Physicians, measured from the time the caller chooses an option that results in the caller being queued for response by a customer service representative.	[redacted]	[redacted]
Telephone Abandon Rate	The number of callers who hang up after their call is queued for response but before the customer service representative actually pulls them off the queue, divided by the total number of callers whose calls are queued.	[redacted]	[redacted]
Total Service Factor	The percent of calls answered within thirty (30) seconds after queuing.	[redacted]	[redacted]

3. UM Program Standards [redacted]

The parties shall utilize their databases and other tools to measure Delegated Entity's compliance against the UM Program standards set forth in the chart below. Delegated Entity shall be responsible for performing the precertification turn-around-time measurements and Company shall be responsible for performing the grievance/appeal overturn rate measurements. In all cases, Company shall notify Delegated Entity within ten (10) days of reversal of an Adverse Determination in accordance with State law or Company policy. Delegated Entity's compliance against the UM Program standards shall be measured for each month during each Program Year, and results reported by the fifteenth (15th) day of the following calendar (or the next business day if the fifteenth day falls on a weekend or legal holiday). The overall results will be a cumulative average for the Program Year.

Measure	Description	Standard	Performance Credit
Pre-Authorization/Pre-Certification Request Turn-Around Time for Standard Requests	The rate of turn-around time for standard requests for pre-authorization or pre-certificate of Diagnostic Imaging Services. A Request for pre-authorization or pre-certification will be counted as a request for the purposes of this guarantee when it is made via designed telephone line, fax line, internet or other means mutually agreed to by Delegated Entity and Company and is in accordance with procedures set forth in the UM Program. The percentage of requests receiving a response within two (2) business days, or other such time as required by Company, will be determined by dividing the number of requests to which Delegated Entity responded within two (2) days, or other such time as required by Company, by the total number of requests made during the same period.	[redacted]	[redacted]
PreAuthorization/Pre-Certification Request Turn-Around Time for Expedited Requests	The rate of turn-around time for requests for expedited pre-authorization or pre-certification of Diagnostic Imaging Services. A request for expedited pre-authorization or pre-certificate will be counted as a request for the purposes of this guarantee when it is made via designated telephone line, fax line, internet or other means mutually agreed to by Delegated Entity and Company and is in accordance with procedures set forth in the UM Program.. The percentage of request receiving a response within eight (8) business hours (or such shorter time as may be required by law, Company or the circumstances of the individual case) will be determined by dividing the number of requests to which Delegated Entity responded within such timeframe by the total number of requests for expedited pre-authorization or pre-certification made during the same period.	[redacted]	[redacted]

Reversal of Adverse Determination	The number of Adverse Determinations reversed during the grievance and appeals process by any Plan, whether through its internal grievance/appeal process or during or as a result of an external appeal, divided by the total number of UM decisions made by Delegated Entity. Reversal of Adverse determinations based in whole or in part on additional information not available to Delegated Entity at the time of the original Adverse Determination, or which in whole or in part are based on reasons other than the medical facts at hand and Clinical Review Criteria shall not be considered Reversals of Adverse Determinations for purposes of determining Delegated Entity's compliance with performance guarantees.	[redacted]	[redacted]

C. Authorization Performance

Standard – Delegated Entity is required to generate an "Authorization File" ("hereinafter referred to as File") of all authorizations created each business day by Delegated Entity and post that File in a mutually agreed upon format by no later than the end of the following business day to the Company FTP site. The File which Delegated Entity must post shall be a full and complete set of all records generated for the previous day's activity. In the event that Delegated Entity experiences system issues which renders it unable to post a complete File on the next business day, Delegated Entity must communicate to Company via email to the designated plan delegation oversight manager, the reason for the delay and combine the delayed authorizations with the next business day's authorization file for posting.

Upon receipt of the File, Company will send Delegated Entity a response file each day in a mutually agreed upon format indicating their acceptance of File load and including records for both accepted and rejected authorizations. Upon receipt of the response file from Company, Delegated Entity will resolve the issues with each rejected record and either resend the completed authorization to Company by including the corrected authorization to the daily batch authorization file or the daily manual file; whichever format deemed necessary by Company

Performance Guarantee – Delegated Entity will send all daily authorization files to Company within three business days of creation. In the event that Delegated Entity fails to meet this standard, it shall pay Company penalty of [redacted] within 30 business days. In any given month the maximum penalty Delegated Entity must pay for failure to meet this standard is [redacted].

All authorization records which have been rejected will be corrected and sent back to Company within three business days of receipt by Delegated Entity. In the event that Delegated Entity does not send at least 98% of rejected authorization within three business days (measured on a monthly basis), Delegated Entity shall pay Company a penalty of [redacted] within 30 business days. In any given month the maximum penalty Delegated Entity must pay for failure to meet this standard is [redacted].

D. 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		X
b. Authorization of referrals in accordance with Delegated Entity's Patient Management Plan as approved by Company, including precertification of referrals to specialists;	X	
c. Precertification 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);		X
d. Precertification 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;	X	
e. Concurrent Review and Discharge Planning;		X
f. Case Management services for catastrophic disease and injury, subject to Section 3, below;		X
g. Disease Management, subject to Section 3, below;		X
h. Service denials, if appropriate, for those same service categories for which Delegated Entity is delegated to perform Precertification;	X	
i. Retrospective Review for those same service categories for which Delegated Entity is delegated to perform Precertification;	X	
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		X
k. Precertification of basic infertility benefits included in a Member's plan;		X
l. Precertification of services included in Comprehensive and Advanced Reproductive Technology Infertility services subject to a Member's eligibility;		X
m. Precertification of Bariatric services subject to a Member's eligibility;		X
n. OOA for capitated services not available within		X

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		**X**

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.

Regulatory Compliance Addendum – Exhibit A
ARIZONA

For purposes of this Regulatory Compliance Addendum, the terms "Provider" or "Subcontractor" mean the health care provider executing this Agreement, as identified on the first page of the Agreement. The term "Company" means Southwest Catholic Health Network Corp. d/b/a Mercy Care Plan and otherwise, except as specified below. This Regulatory Compliance Addendum contains specific provisions that apply to Providers who participate in each program offered by Company. Providers must therefore comply with those provisions of this Exhibit A that apply to each program in which the Provider participates. Providers should note that within the requirements for each program there are provisions that apply only to certain types of providers, so they should take care to identify all of the specific provisions that apply to their specific provider type.

All Providers in every program must also comply with the Minimum Subcontract Requirements listed in Attachment 1 to this Exhibit A.

In the event of any inconsistent or contrary language between this Regulatory Compliance Addendum and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the Regulatory Compliance Addendum shall prevail.

ALTCS Program

1. **All Providers.** The following provisions apply to all Providers who participate in the AHCCCS/ALTCS program (except as designated):

   1.1. If licensed or certified by ADHS, Provider must submit to Company its most recent ADHS licensure review, copies of substantiated complaints, and other pertinent information that is available and considered to be public information from oversight agencies.

   1.2. If Company and Provider have a capitated arrangement/risk sharing arrangement, then the following provision is made part of the Agreement:

   > If the Provider does not bill the Company (e.g., Provider is capitated), the Provider's encounter data that is required to be submitted to the Company pursuant to contract is defined for these purposes as a "claim for payment". The Provider's provision of any service results in a "claim for payment" regardless of whether there is any intention of payment. All said claims shall be subject to review under any and all fraud and abuse statutes, rules and regulations, including but not limited to Arizona Revised Statute (A.R.S.) § 36-2918.

   1.3. A description of Provider's patient medical, dental and cost record keeping system:

   __Electronic __Paper

   If electronic, system name: _____n/a_____

   1.4. Provider acknowledges that AHCCCS is responsible for enrollment, re-enrollment, and disenrollment of the covered population.

   1.5. Provider shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

   1.6. If Provider is a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care services, then Provider must comply with federal and state law advance directive requirements as outlined in 42 CFR 422.128, including:

(1) Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.)

(2) Providing written information to adult members regarding an individual's rights under State law to make decisions regarding medical care and the health care provider's written policies concerning advance directives (including any conscientious objections).

(3) Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.

(4) Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.

(5) Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.

Hospitals, nursing facilities, home health agencies, hospices and organizations responsible for providing personal care services are encouraged to provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

1.7. Provider must train its staff on the following aspects of the Federal False Claims Act provisions: (a) the administrative remedies for false claims and statements; (b) Any state laws relating to civil or criminal penalties for false claims and statements; (c) Whistleblower protections under such laws.

1.8. Provider may not use Company's logo in advertising unless prior approval is received by the AHCCCS Marketing Committee.

1.9 Provider may provide Members factual information, but is prohibited from recommending or steering a Member in the Member's selection of a contractor.

1.10 Provider's responsibility with respect to coordination of benefits and third-party liability are stated in Company's Policies. In addition, Provider agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third-party liability payment before submitting claims to the Company.

1.11 Provider shall cooperate with quality assurance programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM.

1.12 If Provider is delivering Administrative Services, a merger, reorganization or change in ownership of Provider shall require a contract amendment and prior approval of AHCCCS.

1.13 Provider shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and AHCCCS has no responsibility or liability for any such taxes or insurance coverage.

1.14 Company may suspend, deny or refuse to renew or terminate this Agreement in accordance with the terms of the State Contract and applicable law and regulation.

2. **Nursing Facility Providers.** The following provisions apply to nursing facility Providers.

2.1. Provider must refund any payment received from a resident or family member (in excess of share of cost), for the period of time from the effective date of Medicaid eligibility.

2.2. Provider shall not admit a member to a nursing facility without the member first undergoing a Preadmission Screening and Resident Review (PASRR) Level I, and, if needed, a Level II screening. Level I is the identification of members who are suspected of having mental illness or mental retardation. Level II determines whether nursing facility or specialized services are needed. Company may, at its option, recoup any withholding imposed upon Company from Provider if Provider admitted the member without the proper PASRR.

2.3. Provider must have procedures in place to ensure that temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 C.F.R.§ 483.75(e)3 and (g)2. Such registry personnel must also be fingerprinted.

2.4. To the extent this Agreement covers specialty services, such services will be provided under a Work Statement that sets forth the special services being purchased, including admissions criteria, discharge criteria, staffing ratios (if different from non-specialty units), staff training requirements, program description, and other non-clinical services.

3. **Individual Providers.** The following provisions apply to individual Providers.

3.1. A PCP who has an agreement with a hospital, nursing facility, home health agency, hospice or organization providing personal care services must comply with the requirements of Section 1.6.

3.2. A PCP must perform the following activities:

(1) Supervise, coordinate and provide care to each assigned member (except for well woman exams and children's dental services when provided without a PCP referral);

(2) Initiate referrals for medically necessary specialty care;

(3) Maintain continuity of care for each assigned member; and

(4) Maintain the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services.

3.3. Specialty physicians shall not begin a course of treatment for a medical condition other than that for which the member was referred, unless approved by the member's PCP.

4. **Homeless Clinics.** The following provisions apply to Providers designated as homeless clinics.

4.1. Only members that request a homeless clinic as a PCP may be assigned to them.

4.2. Members assigned to a homeless clinic may be referred out-of-network for needed specialty services.

5. **Assisted Living Facilities.** The following provisions apply to Providers that are assisted living facilities.

5.1. To the extent this Agreement covers specialty services, such services will be provided under a Work Statement that sets forth the special services being purchased, including admissions criteria, discharge criteria, staffing ratios (if different from non-specialty units), staff training requirements, program description, and other non-clinical services.

6. **Agency with Choice Providers.** The following provisions apply to all Agency With Choice Providers:

6.1. An authorized representative of the Provider must sign a Member's Service Plan if present at the service plan meeting. Regardless of whether Provider signs the Service Plan, by acceptance of this Agreement, Provider agrees to its roles and responsibilities in implementing the Service Plan, which it will perform in accordance with the terms of the Service Plan, this Agreement and applicable law.

Acute Care Program

1. **All Providers.** The following provisions apply to all Providers who participate in the AHCCCS/Acute Care program (except as designated):

1.1. Provider acknowledges that AHCCCS is responsible for enrollment, re-enrollment, and disenrollment of the covered population.

1.2. If Provider is a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care services, then Provider must comply with federal and state law advance directives for adult members, including:

(1) Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.)

(2) Providing written information to adult members regarding an individual's rights under State law to make decisions regarding medical care and the health care provider's written policies concerning advance directives (including any conscientious objections).

(3) Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.

(4) Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.

(5) Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.

Hospitals, nursing facilities, home health agencies, hospices and organizations responsible for providing personal care services are encouraged to provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

1.3. If Company and Provider have a capitated arrangement/risk sharing arrangement, then the following provision is made part of the Agreement:

If the Provider does not bill the Company (e.g., Provider is capitated), the Provider's encounter data that is required to be submitted to the Company pursuant to contract is defined for these purposes as a "claim for payment". The Provider's provision of any service results in a "claim for payment" regardless of whether there is any intention of payment. All said claims shall be subject to review under any and all fraud and abuse statutes, rules and regulations, including but not limited to Arizona Revised Statute (A.R.S.) § 36-2918.

1.4. A description of Provider's patient medical, dental and cost record keeping system:

__Electronic __Paper

If electronic, system name: _____n/a_____

1.5. Provider shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

1.6 Provider must train its staff on the following aspects of the Federal False Claims Act provisions: (a) the administrative remedies for false claims and statements; (b) Any state laws relating to civil or criminal penalties for false claims and statements; (c) Whistleblower protections under such laws.

1.7. Provider may not use Company's logo in advertising unless prior approval is received by the AHCCCS Marketing Committee.

1.8 Provider may provide Members factual information, but is prohibited from recommending or steering a Member in the Member's selection of a contractor.

1.9 Provider's responsibility with respect to coordination of benefits and third-party liability are stated in Company's Policies. In addition, Provider agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third-party liability payment before submitting claims to the Company.

1.10 Provider shall cooperate with quality assurance programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM.

1.11 If Provider is delivering Administrative Services, a merger, reorganization or change in ownership of Provider shall require a contract amendment and prior approval of AHCCCS.

1.12 Provider shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and AHCCCS has no responsibility or liability for any such taxes or insurance coverage.

1.13 Company may suspend, deny or refuse to renew or terminate this Agreement in accordance with the terms of the State Contract and applicable law and regulation.

2. **Individual Providers.** The following provisions apply to individual Providers:

2.1. If Provider is a PCP and receives a Regional Behavioral Health Authority ("RHBA")/provider information request pertaining to an ADHS behavioral health recipient member, Provider must respond to the request within ten business days of the Provider's receipt of the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last PCP visit, and recent hospitalizations. The PCP must document or initial signifying review of member behavioral health information received from a RBHA behavioral health provider who is also treating the member.

2.2. If Provider is a PCP, has initiated medication management services for a member to treat a behavioral health disorder, and it is determined by Provider or Company that the member should be transferred to a RHBA prescriber for evaluation and/or continued medication management services, Provider or Company shall coordinate the transfer of care.

2.3. Providers that have agreements with a hospital, nursing home, home health agency, hospice or organization responsible for providing personal care services are required to comply with the advance directive provision in Section 1.2.

2.4. Providers who serve EPSDT-aged members will use AHCCCS-approved standard developmental screening tools and be trained in the use of such tools.

2.5. A PCP must perform the following activities:

(1) Supervise, coordinate and provide care to each assigned member (except for well woman exams and children's dental services when provided without a PCP referral);
(2) Initiate referrals for medically necessary specialty care;
(3) Maintain continuity of care for each assigned member; and
(4) Maintain the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services.

2.6. Provider must be registered with AHCCCS as an approved AHCCCS service provider.

3. **Homeless Clinics.** The following provisions apply to Providers designated as homeless clinics.

3.1 Only members that request a homeless clinic as a PCP may be assigned to them.

3.2 Members assigned to a homeless clinic may be referred out-of-network for needed specialty services.

DES/DDD Program

1. **All Providers.** The following provisions apply to all Providers that are contracted to provide services to individuals who are eligible for services through Department of Economic Security/Division of Developmental Disabilities ("DES/DDD") programs to provide long term and medical care to persons with developmental disabilities who are eligible for ALTCS.

1.1. This Agreement incorporates by reference all applicable terms and conditions of the agreement between Company and DES/DDD.
1.2. Provider acknowledges that DDD/DES is responsible for enrollment, re-enrollment and disenrollment of the covered population.
1.3. A Provider that is a hospital, nursing home, home health agency or hospice must comply with the advance directive requirements applicable to Providers providing services to ALTCS members.
1.4. Provider shall meet all applicable licensure, certification, and registration standards established by DES, DDD and AHCCCS and as amended from time to time. Provider shall comply with all applicable DES and DDD administrative rules, policies, procedures, service standards and guidelines, including, but not limited to: (1) hiring of ex-offenders; (2) fingerprinting of Provider staff; (3) completing of Fire Risk Profile requirements; (4) reporting of unusual incidents involving children and/or adults; (5) implementing program audit implementation plans; (6) participating as a member of the Individual Service Plan (ISP) team; (7) complying with all policies, procedures and instructions regarding ISPs; (8) submitting to the DDD's case managers copies of the ISP strategies and other required documentation; and (9) providing copies of member/client records, including evaluations and progress reports.
1.5. Provider shall comply with the Occupational Safety and Health Administration regulations regarding blood borne pathogens, 29 CFR 1910.1030.
1.6. Provider providing services to DDD under this Agreement shall do so in accordance with 42 C.F.R. § 434.6(b), applicable AHCCCS rules and applicable provisions of Federal law and regulations, except for those requirements waived for DES by the Federal government.
1.7. A description of Provider's patient medical, dental and cost record system keeping system:

__Electronic __Paper
If electronic, system name: _____n/a_____

1.8 Provider must train its staff on the following aspects of the Federal False Claims Act provisions: (a) the administrative remedies for false claims and statements; (b) Any state laws relating to civil or criminal penalties for false claims and statements; (c) Whistleblower protections under such laws.

1.9. Provider may not use Company's logo in advertising unless prior approval is received by the AHCCCS Marketing Committee.

Health Care Group of Arizona Program

1. **All Providers.** The following provisions apply to all Providers who participate in the AHCCCS/Health Care Group of Arizona ("HCG") program (except as designated), except if the Provider is a hospital and the AHCCCS agreement between the Provider and Company covers HCG members, these provisions do not apply to the hospital provider:

1.1 Company and Provider shall coordinate benefits as specified in the Group Service Agreement, Member Handbook and any policies and procedures approved or adopted by HCGA and submitted to the Company in writing.
1.2 Provider acknowledges that HCG is responsible for enrollment, re-enrollment, and disenrollment of HCG members.
1.3 By entering into the Agreement, Provider certifies that it does not have any scrutinized business operations in the following countries: Iran, Sudan, and countries that are in violation of the Export Administration Act (terrorist countries).
1.4 Provider must train its staff on the following aspects of the Federal False Claims Act provisions: (a) the administrative remedies for false claims and statements; (b) Any state laws relating to civil or criminal penalties for false claims and statements; (c) Whistleblower protections under such laws.

1.5. Provider may not use Company's logo in advertising unless prior approval is received by the AHCCCS Marketing Committee.

CRS Program

1. **All Providers.** The following provisions apply to all Providers who participate in the Children's Rehabilitative Services ("CRS") program (except as designated), or who are providing CRS services to Members of other Plans:

1.1. This Agreement incorporates by reference all applicable terms and conditions of the agreement between Company and AHCCCS for the CRS program and/or services.
1.2. The terms of this Agreement that apply to Providers participating in the ALTCS or Acute Care Program are applicable to Providers for CRS.
1.3. Provider shall cooperate with Company's care coordination efforts, including the development and carrying out of service plans, the monitoring of Members, and cooperation with Company's care coordinators.
1.4 Provider shall facilitate the exchange of Member health information and medical records in order to support coordinated care. In particular, Provider shall cooperate in the development of an integrated medical record for Members through timely transmission of relevant data and utilization of available electronic health record exchange technology. Providers shall provide Members' PCP updated medical records and information, and shall, within 30 days of first delivering service for a Member, notify Company and the Member's referring provider of such service in writing.
1.5 Provider shall adhere to the appointment standards stated in Company's Policies and Provider Manual.
1.6 Unless a provision of this Agreement requires a longer period, Provider shall retain all Member records until 3 years after the Member has exceeded the age of 18 years or for at least six (6) years after the last date the child received medical or health care services from the Provider, whichever date occurs later.

Medicare Advantage & Medicare Part D Program

1. **All Providers.** The following provisions apply to all Providers who participate in any Medicare Advantage, Medicare Special Needs Plan, Medicare Part D plan or Medicare - Medicaid eligible demonstration plan (a "Medicare plan"):

   1.1 Provider acknowledges that the provisions in 42 C.F.R. § 422.208 relating to physician incentive plans apply to any subcontracting arrangement with a Medicare plan that utilizes physician incentive plan in their payment arrangements with individual physicians or physician groups.

   1.2 Provider is prohibited from imposing any liability upon an enrollee for payment of any fees that are the legal obligation of Company. Provider acknowledges and agrees that 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 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.

   1.3 Provider agrees that HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any of Provider's books, contracts, computer or other electronic systems, including medical records and documentation related to Company's contract with the Centers for Medicare and Medicaid Services. Provider further agrees that the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

   1.4 Any services or other activity performed by Provider pursuant to the Agreement are consistent and comply with the Company's contractual obligations in its agreement with CMS.

   1.5 Upon request by CMS or its designees, Provider shall provide any books, contracts, records, including medical records, and documentation of Company either to Company to provide to CMS or to CMS directly.

   1.6 If CMS or Company determines Provider has not performed satisfactorily, Company may terminate the Agreement and make any reports required by law.

   1.7 Provider's performance under the Agreement is monitored by Company on an ongoing basis. Provider acknowledges that Company is accountable to CMS for any functions and responsibilities described in the regulations governing Medicare Advantage plans. (Medicare Managed Care Manual, § 100.4).

   1.8 Provider acknowledges that Provider's credentials, or the credentials of Provider's affiliated medical professionals, if any, will be either: (i) reviewed by the Company; or (ii) the credentialing process will be reviewed and approved by the Company, which must audit the credentialing process on an ongoing basis. If the selection of providers or subcontractors is delegated to Provider, Company nevertheless reserves the right to approve, suspend, or terminate any such arrangement.

   1.9 Provider must comply with all applicable Medicare laws, regulations, and CMS instructions.

   1.10 To the extent Provider submits data to support payment to Company by CMS (including enrollment information, encounter or claims data, or other information CMS may specify), Provider must certify

(based on best knowledge, information and belief) the accuracy, completeness and truthfulness of the data, and acknowledge that claims data will be used for purposes of obtaining federal reimbursement.

1.11 If applicable, Company will regularly update its prescription drug pricing standard consistent with the time frames set forth in 42 C.F.R. § 423.505(b)(21).

1.12 Provider agrees to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records. (Medicare Managed Care Manual, § 100.4). Provider 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.

1.13 Provider 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.

1.14 In the event this Agreement does not otherwise contain a prompt payment provision, Company agrees to pay Provider within 45 days of Provider's submission of a clean claim for services provided to members. A "clean claim" shall mean a claim for Provider services that has no defect or impropriety requiring special treatment that prevents timely payment by Company.

1.15 In addition to any other method specified in the Agreement, this Agreement may be modified and amended by the mutual written consent of both Parties.

1.16 Provider acknowledges that Mercy Care may only delegate activities or functions to Provider in a manner consistent with Medicare laws, rules and regulations. Provider acknowledges and agrees that if any of Mercy Care's activities or responsibilities under Mercy Care's contract with CMS and Government Sponsor to offer Plans is delegated by Mercy Care to Provider, such activity or responsibility may be revoked if CMS or Mercy Care determines that Provider has not performed satisfactorily. To the extent Mercy Care has delegated activities or functions to Provider pursuant to a separate delegation agreement, such agreement shall specify the duties and reporting obligations of Provider, and the terms of this Addendum shall be incorporated therein, if not already expressly stated therein. Provider's performance of such delegated activities shall be monitored by Mercy Care on an ongoing basis.

If Mercy Care consents, Provider may sub-delegate a portion of its responsibilities under the Agreement to a third party approved by Mercy Care ("Sub-Delegate"); provided, however, Provider agrees that it is responsible for ensuring that any Sub-Delegate adheres to the requirements of this Addendum and the Agreement; provided, further, Provider and any Sub-Delegated entity shall enter into an agreement setting forth the respective responsibilities of the parties, which shall comply with applicable accreditation standards. Such sub-delegation shall not relieve Provider of its obligations under this Addendum or the Agreement. Provider acknowledges and agrees that all provisions of this Agreement shall apply equally to any Sub-Delegate that provides any services under this Agreement, and Provider represents and warrants that it shall take all steps necessary to cause such Sub-Delegates to comply with this Agreement and all applicable laws, rules and regulations. Provider further acknowledges and agrees that any contract that Provider enters into with a Sub-Delegate relating to any services that Provider is responsible to perform under this Agreement for Medicare Members ("Delegated Subcontract"): (i) must contain provisions that require the Sub-Delegate to comply with any and all obligations and duties imposed on Provider in this Agreement (ii) must contain all provisions required under Medicare laws, rules and regulations, and (iii) is subject to all of Mercy Care's obligations under Medicare laws, rules and regulations related to such Delegated Subcontract.

1.17 The credentials of medical professionals affiliated with Provider will be reviewed by Mercy Care in accordance with Mercy Care's polices as stated in the Agreement. If such credentialing process has been delegated to Provider as a part of this Agreement or in a separate Agreement, the credentialing process

will be reviewed and approved by Mercy Care and Mercy Care shall audit the credentialing process on an ongoing basis. If Mercy Care has delegated a selection of providers, contractors, or subcontractors, Mercy Care shall retain the right to approve, suspend or terminate any arrangement with a provider, contractor or subcontractor.

1.18 Provider shall continue to provide services under the Agreement to Members in the event of (i) Mercy Care's insolvency, (ii) Mercy Care's discontinuation of operations or (iii) termination of the CMS Contract, throughout the period for which CMS payments have been made to Mercy Care, and for Members who are hospitalized, until such time as the Member is appropriately discharged.

2. **Physician Groups.** The following provisions apply to Physician Groups
   2.1 The participation procedures set forth in 42 C.F.R. § 422.202(a) applies to Provider's physicians.

3. **Long Term Care Pharmacies.** The following provisions apply to Long Term Care Pharmacies.
   3.1 If Provider is a pharmacy located in, or having a contract with, a long term care facility (as defined in 42 C.F.R. § 423.100), Provider must have not less than 30 days, nor more than 90 days, to submit to Company claims for reimbursement under the Part D plan.

Regional Behavioral Health Authority Program

1. **All Providers.** The following provisions apply to all Providers who participate in the program offered pursuant to contract with ADHS for the Regional Behavioral Health Authority ("RBHA"):

   1.1. The terms and conditions of the State Contract are incorporated herein by reference. Provider shall comply with such terms as applicable, including the terms of documents incorporated therein by reference.

   1.2. Provider warrants that it is in compliance with all federal immigration laws and regulations and a breach of this warranty shall be deemed a material breach of this Agreement, subject to financial sanctions or termination of the Agreement.

   1.3. Provider's responsibility with respect to coordination of benefits and third-party liability are stated in Company's Policies. In addition, Provider agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third-party liability payment before submitting claims to the Company.

   1.4. Provider shall maintain an appropriate service delivery cost record keeping system. Provider will give Company a description of Provider's system upon request.

   1.5. Provider shall comply with ADHS/DBHS and Company's quality management and medical management programs in conformance with 42 CFR Part 456, and the AHCCCS Medical and Policy Manual.

   1.6. A merger, reorganization or change in ownership or control of Provider, if Provider is related to or affiliated with Company, shall require an amendment to this Agreement and prior approval of ADHS/DBHS.

   1.7. In addition to any insurance requirements of this Agreement, Provider shall obtain and maintain all insurance requirements in conformance with the State Contract, Special Terms and Conditions, Section T, Insurance Requirements and to submit a copy of all certificates of insurance to the Company upon request. Provider must provide Certificates of Insurance (ACORD) upon subcontract execution.

   1.8. Provider shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and AHCCCS has no responsibility or liability for any such taxes or insurance coverage.

1.9. Provider shall comply with the encounter reporting and claims submission requirements in accordance with Section 17.11 and the ADHS/DBHS Provider Manual, 6.2,Submitting Claims and Encounters to the RBHA.

1.10. Provider shall appeal a claim denial in accordance with this Agreement, Company's Policies, Section 13.5 and the ADHS/DBHS Provider Manual, 5.6, Provider Claims Disputes, assist members in understanding their right to file grievances and appeals in conformance with the ADHS/DBHS Provider Manual, 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons, and to implement ADHS/DBHS, AHCCCS, or Company decisions issued to resolve a complaint, SMI grievance, member appeal, or claim dispute.

1.11. Provider shall comply with audits, inspections and reviews in conformance with the ADHS/DBHS Provider Manual, 8.1, Encounter Validation Studies, 8.5, Medical Care Evaluation Studies and any audits, inspections and reviews requested by Company, ADHS/DBHS, or AHCCCS.

1.12. Provider shall cooperate with ADHS contractors or state employees in scheduling and coordinating services.

1.13. Provider may not pay incentives in the form of compensation to individuals or entities that conduct Provider's utilization management activities to deny, limit, or discontinue medically necessary services. Provider shall comply with all federal and state regulations regarding physician incentive contracts.

1.14. Provider must conduct an assessment of cultural and linguistic needs, and deliver culturally appropriate services in conformance with ADHS/DBHS' Cultural Competency Plan and Company's Cultural Competency Plan. Interpretation services are available to assist members who speak a language other than English or who use sign language.

1.15. "Medically Necessary Services" are defined in accordance with the ADHS/DBHS' definition.

1.16. Provider acknowledges that AHCCCS is responsible for enrollment, re-enrollment, and disenrollment of the covered population.

1.17. Company may suspend, deny, refuse to renew or terminate this Agreement or any subcontract in accordance with the terms of this Contract and applicable law and regulation. Company may monitor Provider's performance relative to industry standards and state law regulations on an ongoing basis according to a periodic schedule approved by ADHS/DBHS, and require Provider subcontractor to initiate a corrective action plan as necessary. Company may revoke delegation or impose sanctions for inadequate performance of delegated services.

1.18. Provider may provide Members with factual information, but is prohibited from recommending or influencing a Member's selection of Company or another plan. Provider is permitted to provide services to ADHS/DBHS, AHCCCS or any other ADHS/DBHS or AHCCCS contractor.

1.19. Nothing in this Agreement may be construed as a barrier to Provider's communications with patients regarding their health status, medical care or treatment options, including any alternative treatment that may be self-administered; any information the member needs in order to decide among all relevant treatment options including the risks, benefits, and consequences of treatment or non-treatment; and the member's right to participate in health care decisions including the right to refuse treatment, and to express preferences about future treatment decisions. Discussions related to such matters shall be documented. If Provider is a hospital, nursing facility, home health agency, hospice or organization

responsible for providing personal care services, then Provider must comply with federal and state law advance directive requirements as outlined in 42 CFR 422.128. To the extent possible, peers or family members must be included in the interview process for direct service staff positions and for child members.

1.20. If Company and Provider have a capitated arrangement/risk sharing arrangement, then the following provision is made part of the Agreement:

> If the Provider does not bill the Company (e.g., Provider is capitated), the Provider's encounter data that is required to be submitted to the Company pursuant to contract is defined for these purposes as a "claim for payment". The Provider's provision of any service results in a "claim for payment" regardless of whether there is any intention of payment. All said claims shall be subject to review under any and all fraud and abuse statutes, rules and regulations, including but not limited to Arizona Revised Statute (A.R.S.) § 36-2918.

1.21. Provider must obtain authorization for services which require prior authorization.

1.22. Provider may not arbitrarily or prematurely deny, suspend or terminate services to a Member. Provider will deliver timely and accessible services to Medicaid eligible members in the amount, duration and scope as those services are available to Non-Medicaid eligible persons within the same service area. Provider may not limit or deny Members' access to an available facility; Provider Members any medically necessary, covered service which is different, or is provided in a different manner or at a different time from other patients, other public or private recipients of care or the public at large, except where medically necessary; or segregate or separate treatment to a member; restrict a member in his or her enjoyment of any advantage or privilege offered to others receiving any covered service. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or intellectual disability of the members to be served is also prohibited.

1.23. Provider must cooperate with Company's required efforts to collect and submit information to ADHS/DBHS in conformance with the specifications in the Provider Affiliation Transmission User Manual.

1.24. Provider shall have a license, registration, certification or accreditation in conformance with the ADHS/DBHS Covered Behavioral Health Services Guide, or other state or federal law and regulations; Register with AHCCCS as applicable or in conformance with the ADHS/DBHS Covered Behavioral Health Services Guide; sign this Agreement; and Obtain a unique National Provider Identifier (NPI).

1.25. Provider shall comply with the appointment standards contained in Company's Policies, the ADHS/DBHS Provider Manual, 3.2, Appointment Standards and Timeliness of Services, and the State Contract., as applicable.

1.26. All services under this Agreement must be performed within the defined territories of the United States, including work related to indirect or overhead services, redundant/back-up services or services that are incidental to the performance of this Agreement.

1.27. Provider and Provider's employees shall participate in and cooperate with Company's state-required training and orientation programs.

1.28. Provider shall maintain Member medical records in an accurate legible fashion, in compliance with Company's standards and the ADHS/DBHS Provider Manual, 4.2, Behavioral Health Medical Record

Standards. Such records must contain consent and authorization for medical records as prescribed in A.R.S. § 12-2297 and in conformance with Section 4.2. Provider is the owner of Members' medical records, however, Company retains the discretion to review such records, including in circumstances related to the administration of service delivery and investigations for fraud. ADHS/DBHS is permitted access to all members' medical records within the time specified by ADHS/DBHS. Members must be allowed at least one free copy of their medical record each year.

1.29. Neither Provider nor Company may withhold information from ADHS/DBHS as proprietary. Information designated as confidential may be disclosed by ADHS/DBHS as required by law.

2. **Level I, II, or III facilities.** Such facilities must:

2.1. Accept all referrals from Company;

2.2. Comply with Company's quality management and medical management programs;

2.3. If serving juveniles, comply with the relevant provisions of ARS § 36-1201.

3. **Homeless Clinics.** Only those SMI members that request a homeless clinic as their PCP receive such assignment. SMI members assigned to a homeless clinic may be referred to out-of-network providers for needed specialty services.

4. **Primary Care Providers.** Primary Care Providers are responsible, at a minimum for the following activities:

4.1. Supervision, coordination and provision of care to each assigned member; except for dental services provided to EPSDT members without a PCP referral;

4.2. Initiation of referrals for medically necessary specialty care;

4.3. Maintaining continuity of care for each assigned member;

4.4. Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services;

4.5. Utilizing the AHCCCS approved EPSDT Tracking Forms;

4.6. Providing clinical information regarding member's health and medications to the treating provider, including behavioral health providers or new PCP's, within ten (10) business days of a request from the provider; and

4.7. Enrolling as a Vaccines for Children (VFC) provider for member's age eighteen (18) only.

5. **Labor and Delivery.** All physicians and certified nurse midwives who perform deliveries must have OB hospital privileges or a documented hospital coverage agreement when performing deliveries in alternate settings. Certified midwives may perform deliveries only in the Member's home. Physicians, certified nurse practitioners and certified nurse midwives within the scope of their practice may provide labor and delivery services in the Member's home.

6. **Prevention Service Delivery Subcontracts.** Prevention subcontracts must be specific to prevention and separate from subcontracts for other covered services. If this is a subcontract for prevention, Provider must:

6.1. Comply with the ADHS/DBHS Prevention Framework for Behavioral Health;

6.2. Specify to Company the work to be performed; type, duration and scope of the prevention strategy to be delivered; and approximate number of participants to be served;

6.3. Describe to Company the evaluation methods to monitor performance and the specific reporting requirements; and

6.4. Comply with relevant SAPT Block Grant requirements.

7. **Management Services Contractors.** All such contractors must prepare a Business Continuity and Recovery Plan satisfactory to Company.

8. The plan under the ADHS RBHA contract is offered by Mercy Maricopa Integrated Care ("Mercy Maricopa"), a health plan sponsored by Southwest Catholic Health Network Corp. and Maricopa Integrated Health System. Provider shall participate in that plan in accordance with the terms of this Agreement, the Provider Manual and polices for RBHA, and Mercy Maricopa may itself seek redress for breaches thereof. Unless formally delegated by Mercy Maricopa to Company, the obligations of this Agreement as respecting Mercy Maricopa-offered lines of business are Mercy Maricopa's alone.

9. Providers participating in Mercy Maricopa's product under the ADHS RBHA contract agree to also participate in Mercy Maricopa's Medicare (Medicare Advantage, SNP or Medicare-Medicaid dual eligible demonstration) plan for those RBHA-product Members who are dually eligible for Medicare and Medicaid. To the extent applicable, the CMS-required terms and conditions stated in this Addendum for Mercy Care Advantage shall also apply to such plan.

Family Planning Benefits

Notwithstanding any other provision of this Agreement, and exclusively with respect to Family Planning services rendered by Provider pursuant to this Agreement, any reference in this Agreement or Company's policies and procedures to "Mercy Care" (or to Southwest Catholic Health Network Corporation dba Mercy Care Plan, Mercy HealthCare Group, and Mercy Care Advantage, or otherwise) shall be replaced with "Plan Administrator" for purposes of: (i) performing obligations or enforcing rights directly connected to the administration of Family Planning services; (ii) exchanging any payment, correspondence, information (including without limitation Encounter Data and claims data) or reports between Company and Provider.
"Plan Administrator" shall mean Schaller Anderson, LLC, or such other entity designated by Company and identified to Provider in writing. Notices and other correspondence submitted to Plan Administrator under this Agreement shall be sent to the following address:

Aetna Medicaid Administrators, LLC
Attention: Legal Department
4645 E. Cotton Center Blvd.
Building 1
Phoenix, Arizona 85040

With copy to

Mercy Care Plan
Attention: Network Development and Contracting
4350 E. Cotton Center Blvd.
Building D
Phoenix, AZ 85040

For purposes of this Agreement, Family Planning services shall mean those services in accordance with the AHCCCS Medical Policy Manual for all members (male and female) who choose to delay or prevent pregnancy. These include medical, surgical, pharmacological and laboratory services, as well as contraceptive devices. Information and counseling, which allow members to make informed decisions regarding family planning methods, shall also be included.

Exhibit A - Attachment 1
Minimum Subcontract Provisions

The provisions in this Section are required by the State Contract and apply to all provider types, unless otherwise indicated. Pursuant to the State Contract, "subcontract" in this Section refers to the Agreement and "Contractor" refers to the Company.

1. ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES

No payment due the Subcontractor under this subcontract may be assigned without the prior approval of the Contractor. No assignment or delegation of the duties of this subcontract shall be valid unless prior written approval is received from the Contractor.

2. AWARDS OF OTHER SUBCONTRACTS

AHCCCS and/or the Contractor may undertake or award other contracts for additional or related work to the work performed by the Subcontractor and the Subcontractor shall fully cooperate with such other contractors, subcontractors or state employees. The Subcontractor shall not commit or permit any act which will interfere with the performance of work by any other contractor, subcontractor or state employee.

3. CERTIFICATION OF COMPLIANCE — ANTI-KICKBACK AND LABORATORY TESTING

By signing this subcontract, the Subcontractor certifies that it has not engaged in any violation of the Medicare Anti-Kickback statute (42 USC §§1320a-7b) or the "Stark I and "Stark II" laws governing related-entity referrals (PL 101-239 and PL 101-432) and compensation there from. If the Subcontractor provides laboratory testing, it certifies that it has complied with 42 CFR §411.361 and has sent to AHCCCS simultaneous copies of the information required by that rule to be sent to the Centers for Medicare and Medicaid Services. (42 USC §§1320a-7b; PL 101-239 and PL 101-432; 42 CFR §411.361)

4. CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION

By signing this subcontract, the Subcontractor certifies that all representations set forth herein are true to the best of its knowledge.

5. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

The Clinical Laboratory Improvement Amendment (CLIA) of 1988 requires laboratories and other facilities that test human specimens to obtain either a CLIA Waiver or CLIA Certificate in order to obtain reimbursement from the Medicare and Medicaid (AHCCCS) programs. In addition, they must meet all the requirements of 42 CFR 493, Subpart A.

To comply with these requirements, AHCCCS requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories.

Pass-through billing or other similar activities with the intent of avoiding the above requirements are prohibited. The Contractor may not reimburse providers who do not comply with the above requirements. (CLIA of 1988; 42 CFR 493, Subpart A)

6. COMPLIANCE WITH AHCCCS RULES RELATING TO AUDIT AND INSPECTION

The Subcontractor shall comply with all applicable AHCCCS Rules and Audit Guide relating to the audit of the Subcontractor's records and the inspection of the Subcontractor's facilities. If the Subcontractor is an

inpatient facility, the Subcontractor shall file uniform reports and Title XVIII and Title XIX cost reports with AHCCCS. (A.R.S. §41-2548; 45 CFR 74.48 (d))

7. COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS

The Subcontractor shall comply with all federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this subcontract, without limitation to those designated within this subcontract. [42 CFR 434.70] [42 CFR 438.6(l)]

8. CONFIDENTIALITY REQUIREMENT

The Subcontractor shall safeguard confidential information in accordance with Federal and State laws, regulations, policies and AHCCCS directives including but not limited to, 42 CFR Part 431, Subpart F, ARS §36-107, §36-2903 (for Acute), §36-2932 (for ALTCS), §41-1959 and §46-135, the Health Insurance Portability and Accountability Act (Public Law 107-191 Statutes 1936), 45 CFR Parts 160 and 164, and AHCCCS Rules.

9. CONFLICT IN INTERPRETATION OF PROVISIONS

In the event of any conflict in interpretation between provisions of this subcontract and the AHCCCS Minimum Subcontract Provisions, the latter shall take precedence.

10. CONTRACT CLAIMS AND DISPUTES

Contract claims and disputes arising under A.R.S. Title 36, Chapter 29 shall be adjudicated in accordance with AHCCCS Rules, A.R.S. §36-2901 et seq. (for Acute) and A.R.S. §36-2931 et seq. (for ALTCS).

11. ENCOUNTER DATA REQUIREMENT

If the Subcontractor does not bill the Contractor (e.g., Subcontractor is capitated), the Subcontractor shall submit encounter data to the Contractor in a form acceptable to AHCCCS.

12. EVALUATION OF QUALITY, APPROPRIATENESS, OR TIMELINESS OF SERVICES

AHCCCS or the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness or timeliness of services performed under this subcontract.

13. E-VERIFY REQUIREMENTS

In accordance with A.R.S. §41-4401, the Contractor and Subcontractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. §23- 214, Subsection A.

14. FEDERAL IMMIGRATION AND NATIONALITY ACT

The Subcontractor shall comply with all Federal, State and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Subcontractor shall flow down this requirement to all Subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Contractor and Subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any Subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Contractor.

15. FRAUD AND ABUSE

If the Subcontractor discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, the Subcontractor shall report the incident to the prime Contractor as well as to AHCCCS, Office of the Inspector General (OIG). All incidents of potential fraud should be reported to the OIG.

16. GENERAL INDEMNIFICATION

The parties to this contract agree that AHCCCS shall be indemnified and held harmless by the Contractor and Subcontractor for the vicarious liability of AHCCCS as a result of entering into this contract. However, the parties further agree that AHCCCS shall be responsible for its own negligence. Each party to this contract is responsible for its own negligence.

17. INSURANCE

The Contractor and Subcontractor are required to maintain insurance, at a minimum, as specified in Attachment E-1, Standard Professional Service Contracts and E-2, Standard Professional Service Contracts – Under $50,000. For policies for insurance for professional service contracts working with children or vulnerable adults the policy shall be endorsed to include coverage for sexual abuse and molestation.

18. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in federal and state law and regulations, the Subcontractor shall not bill, or attempt to collect payment from a person who was AHCCCS eligible at the time the covered service(s) were rendered, or from the financially responsible relative or representative for covered services that were paid or could have been paid by the System.

19. MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

The Subcontractor shall be registered with AHCCCS and shall obtain and maintain all licenses, permits and authority necessary to do business and render service under this subcontract and, where applicable, shall comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation.

20. NON-DISCRIMINATION REQUIREMENTS

The Subcontractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, gender, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The Subcontractor shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability. (Federal regulations, State Executive order # 99-4)

21. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and involve access to secure or sensitive data or personal client data shall be performed within the defined territories within the borders of the United States. Unless specifically stated otherwise in specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by Subcontractors at all tiers.

22. PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

The Contractor and Subcontractor shall develop, maintain and use a system for Prior Authorization and Utilization Review that is consistent with AHCCCS Rules and the Contractor's policies.

23. RECORDS RETENTION

The Subcontractor shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. The Subcontractor shall comply with all specifications for record keeping established by AHCCCS. All books and records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Subcontractor agrees to make available at all reasonable times during the term of this contract any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government.

The Subcontractor shall preserve and make available, at no cost, all records for a period of five years from the date of final payment under this contract unless a longer period of time is required by law.

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available, at no cost, for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the Subcontractor for a period of five years after the date of final disposition or resolution thereof unless a longer period of time is required by law. [45 CFR 74.53; 42 CFR 431.17; A.R.S. §41-2548]

24. SCRUTINIZED BUSINESS

In accordance with A.R.S. §35-391 and A.R.S. §35-393, Contractor and Subcontractor certifies that the Contractor does not have scrutinized business operations in Sudan or Iran.

25. SEVERABILITY

If any provision of these subcontract terms and conditions is held invalid or unenforceable, the remaining provisions shall continue valid and enforceable to the full extent permitted by law.

26. SUBJECTION OF SUBCONTRACT

The terms of this subcontract shall be subject to the applicable material terms and conditions of the contract existing between the Contractor and AHCCCS for the provision of covered services.

27. TERMINATION OF SUBCONTRACT

AHCCCS may, by written notice to the Subcontractor, terminate this subcontract if it is found, after notice and hearing by the State, that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Subcontractor, or any agent or representative of the Subcontractor, to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of the Subcontractor; provided, that the existence of the facts upon which the state makes such findings shall be in issue and may be reviewed in any competent court. If the subcontract is terminated under this section, unless the Contractor is a governmental agency, instrumentality or subdivision thereof, AHCCCS shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by the Subcontractor in providing any such gratuities to any such officer or employee. [AAC R2-5-501; ARS 412616 C.; 42 CFR 434.6, a. (6)]

28. VOIDABILITY OF SUBCONTRACT

This subcontract is voidable and subject to immediate termination by AHCCCS upon the Subcontractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or upon assignment or delegation of the subcontract without AHCCCS' prior written approval.

29. WARRANTY OF SERVICES

The Subcontractor, by execution of this subcontract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract.

ATTACHMENT E-1 to Exhibit A Attachment 1

STANDARD PROFESSIONAL SERVICE CONTRACT

INDEMNIFICATION CLAUSE:

Contractor and Subcontractors shall indemnify, defend, save and hold harmless the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or Subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any Federal, State or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State of Arizona.

This indemnity shall not apply if the Contractor or Subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

INSURANCE REQUIREMENTS:

Contractor and Subcontractors shall procure and maintain until all of their obligations have been discharged, including any warranty periods under this contract, are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by the Contractor, his agents, representatives, employees or Subcontractors.

The *insurance requirements* herein are minimum requirements for this contract and in no way limit the indemnity covenants contained in this contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might arise out of the performance of the work under this contract by the Contractor, its agents, representatives, employees or Subcontractors, and Contractor is free to purchase additional insurance.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below.

1. **Commercial General Liability – Occurrence Form**

Policy shall include bodily injury, property damage, personal injury and broad form contractual liability coverage.

• General Aggregate	$2,000,000
• Products – Completed Operations Aggregate	$1,000,000
• Personal and Advertising Injury	$1,000,000
• Blanket Contractual Liability – Written and Oral	$1,000,000
• Fire Legal Liability	$50,000
• Each Occurrence	$1,000,000

a. If applicable, the policy shall be endorsed to include coverage for sexual abuse and molestation.

b. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor".***

c. Policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

2. **Business Automobile Liability**

Bodily Injury and Property Damage for any owned, hired, and/or non-owned vehicles used in the performance of this contract.

Combined Single Limit (CSL) $1,000,000

a. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor".***

b. Policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

3. **Worker's Compensation and Employers' Liability**

Workers' Compensation Statutory

Employers' Liability

Each Accident	$ 500,000
Disease – Each Employee	$ 500,000
Disease – Policy Limit	$1,000,000

a. Policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

b. This requirement shall not apply to: Separately, EACH Contractor or Subcontractor exempt under A.R.S. §23-901, AND when such Contractor or Subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

4. **Professional Liability (Errors and Omissions Liability)**

Each Claim	$1,000,000
Annual Aggregate	$2,000,000

a. In the event that the professional liability insurance required by this contract is written on a claims-made basis, Contractor warrants that any retroactive date under the policy shall precede the effective

date of this contract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under this contract is completed.

b. The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work of this contract.

B. **ADDITIONAL INSURANCE REQUIREMENTS:**
The policies shall include, or be endorsed to include, the following provisions:

1. The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees wherever additional insured status is required. Such additional insured shall be covered to the full limits of liability purchased by the Contractor, even if those limits of liability are in excess of those required by this contract.
2. The Contractor's insurance coverage shall be primary insurance with respect to all other available sources.
3. Coverage provided by the Contractor shall not be limited to the liability assumed under the indemnification provisions of this contract.

C. **NOTICE OF CANCELLATION:** With the exception of (10) day notice of cancellation for non-payment of premium, any changes material to compliance with this contract in the insurance policies above shall require (30) days written notice to the State of Arizona. Such notice shall be sent directly to AHCCCS Contracts Unit, Mail Drop 5700, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034 and shall be sent by certified mail, return receipt requested.

D. **ACCEPTABILITY OF INSURERS:** Insurance is to be placed with duly licensed or approved non-admitted insurers in the state of Arizona with an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. **VERIFICATION OF COVERAGE:** Contractor and Subcontractor shall furnish the State of Arizona with certificates of insurance (ACORD form or equivalent approved by the State of Arizona) as required by this contract. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

All certificates and endorsements are to be received and approved by the State of Arizona before work commences. Each insurance policy required by this contract must be in effect at or prior to commencement of work under this contract and remain in effect for the duration of the project. Failure to maintain the insurance policies as required by this contract, or to provide evidence of renewal, is a material breach of contract.

All certificates required by this contract shall be sent directly to AHCCCS Contracts Unit, Mail Drop 5700, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034. All subcontractors are required to maintain insurance and to provide verification upon request. The State of Arizona project/contract number and project description shall be noted on the certificate of insurance. The State of Arizona reserves the right to require complete, certified copies of all insurance policies required by this contract at any time. **DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATE OF ARIZONA'S RISK MANAGEMENT DIVISION.**

F. **SUBCONTRACTORS:** Contractors' certificate(s) shall include all Subcontractors as insureds under its policies **or** upon request, the Contractor shall furnish to the State of Arizona separate certificates and endorsements for each Subcontractor upon request. All coverages for Subcontractors shall be subject to the minimum requirements identified above.

G. **APPROVAL:** Any modification or variation from the *insurance requirements* in this contract shall be made by the contracting agency in consultation with the Department of Administration, Risk Management Division. Such action will not require a formal contract amendment, but may be made by administrative action.

H. **EXCEPTIONS**: In the event the Contractor or Subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a Certificate of Self-Insurance. If the Contractor or Subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.

By:_____

Printed Name:_____

Title:_____

Date:_____

Southwest Catholic Health Network Corporation

By:_____

Printed Name: _____

Title:_____

Date:_____

Effective Date: ---------- ----------

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

Mercy Care Plan
Attention: CEO
4350 E. Cotton Center Blvd.
Building D
Phoenix, AZ 85040

PRODUCT PARTICIPATION SCHEDULE

Participation under this Agreement will include the products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Mercy Care Plan (Acute, ALTCS, DD)
- Mercy Care Advantage
- Mercy Maricopa Advantage
- Regional Behavioral Health Authority

Individual Sites Regulatory Addendum – Exhibit A

DELAWARE

If there is any conflict between the terms of this **Exhibit A** and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this **Exhibit A** will govern and control; provided, however, if there is any conflict between any of the terms of this Agreement, including this **Exhibit A**, and the applicable State Contract (as defined in this Agreement), then the terms of the State Contract will govern and control.

The term "Provider," as it appears throughout this **Exhibit A**, shall refer to Delegated Entity.

I. STATE-REQUIRED TERMS

In addition to the General Provisions, other Attachments, and items incorporated into the Agreement by reference, the terms and conditions of this Attachment B are applicable to the services PHP provides to individuals enrolled with DPCI under the Diamond State Health DPCI ("DSHP") program. In the event of any conflict between (1) the terms of this Attachment B on the one hand, and (2) the General Provisions, other Attachments or items incorporated into the Agreement by reference (except for Applicable Law) on the other hand, the terms of this Attachment B shall control for PHP's services to DPCI's DSHP Members.

ADDITIONAL DEFINITIONS

In connection with PHP's services to DPCI's DSHP Members, the following defined terms shall apply throughout the Agreement as set forth below. Other defined terms are set forth in the General Provisions and Attachment A of the Agreement.

Clean Claim means a claim that may be processed without obtaining additional information from the provider of service or from a third party and can pass all edits required for payments by DPCI.

Emergency Medical Condition means medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

2. Serious impairment to bodily functions;

3. Serious impairment or dysfunction of any bodily organ or part; or

4. Serious disfigurement of such person.

Emergency Medical Services means with respect to DPCI's DSHP Members, the Covered inpatient and outpatient Services that DPCI is obligated to cover under the DPCI Contract and that are (i) furnished by a provider that is qualified to furnish such services under Applicable Law and (ii) are needed to evaluate or stabilize an Emergency Medical Condition as defined in this Attachment B.

Medically Necessary or **Medical Necessity** means those Covered Services that a prudent physician acting within the scope of his or her license under State law would provide to a patient for the purpose of diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:

1. In accordance with generally accepted standards of medical practice;

2. Consistent with the symptoms or treatment of the condition; and

3. Not solely for anyone's convenience.

State means the State of Delaware.

State Agency means the Delaware Department of Health and Social Services.

II. SPECIFIC TERMS

A. Claims and Encounter

Claims and Encounters (and resubmitted claims and Encounters) shall be addressed and mailed to:

Delaware Physicians Care, Incorporated
P.O. Box 61145
Phoenix, AZ 85082-1145

B. Indemnification

DPCI shall indemnify and hold PHP and its officers, directors, managers and employees harmless from and against any claims, actions, suits, proceedings, investigations, demands, fines, liabilities, overpayments, penalties, judgments, settlements, damages, losses, costs and expenses (including reasonable legal fees) that result from, relate to, arise out of, or are a direct or indirect result of DPCI's performance or non-performance of DPCI's obligations under this Agreement.

C. Notices

Any notices required under this Agreement shall be delivered to DPCI at:

Delaware Physician Care, Incorporated
252 Chapman Road
Newark, Delaware, 19702

III. REQUIRED PROVISIONS

A. Availability of Services

PHP shall offer DPCI's DSHP Members hours of operation that are the same as those offered to all other patients, including (without limitation) commercial enrollees or those patients covered by Delaware's Medicaid fee-for-service or Diamond State Partners programs if PHP serves only Medicaid enrollees. PHP shall also make Covered Services available to DPCI's DSHP Members 24 hours a day, 7 days a week, when Medically Necessary.

B. Mainstreaming of Members

1. PHP shall accept DPCI's DSHP Members for diagnosis and treatment in no less the manner as it accepts all other patients. PHP shall not intentionally segregate DPCI's DSHP Members in any way from other persons receiving services. Segregating practices prohibited by the preceding sentence include, but are not limited to, the following:

    a. Denying or not providing a Member a Covered Service or availability of a facility that PHP has agreed to make available under the Agreement.

    b. Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service.

    c. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, program membership, or physical or mental handicap of the participants to be served.

    d. If applicable, restricting Medicaid clients to a clinic practice when a contracting provider has office appointments for the non-Medicaid client.

2. If applicable, PHP shall not close its patient panel to DPCI's DSHP Members alone. If PHP closes its panel, such panel closure must be applicable to all patients and if the panel is reopened, PHP shall admit patients, including DPCI's DSHP Members on a first-come, first-served basis.

3. PHP shall not provide to a DPCI DSHP Member any Covered Service that is different, or is provided in a different manner or at a different time from that provided to other Members, other public or private patients or the public at large.

4. PHP shall furnish Covered Services to all DPCI DSHP Members without regard to the Member's enrollment category or as a private purchaser of the Covered Services or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when PHP should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

C. Member Hold Harmless

1. In the event of DPCI's or its designated intermediary's (if any) insolvency or other cessation of operations, PHP shall continue to provide Covered Services to DPCI's DSHP Members through the period for which capitation has been paid to DPCI for the Member or until the Member's discharge from an inpatient facility, whichever time is greater. Covered Services to DPCI's DSHP Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until confinement in an inpatient facility is no longer Medically Necessary.

2. PHP shall not, in any event, collect or attempt to collect from an DPCI DSHP Member any money owed to PHP by DPCI.

D. Provider Dispute Procedures

DPCI shall establish informal and formal procedures for resolution of administrative, payment or other disputes between DPCI and PHP as required by Applicable Law and describe such procedures in the Provider Manual.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.

By:_____

Printed Name:_____

Title:_____

Date:_____

Delaware Physicians Care, Incorporated

By:_____

Printed Name: _____

Title:_____

Date:_____

Effective Date:_____

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

Delaware Physicians Care, Incorporated
252 Chapman Road
Newark, Delaware, 19702
Attention: CEO

PRODUCT PARTICIPATION SCHEDULE

Participation under this Agreement will include the products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Those Medicaid Plans and programs offered by Company within the State of Delaware.

Individual Sites Regulatory Addendum – Exhibit A

ILLINOIS

If there is any conflict between the terms of this **Exhibit A** and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this **Exhibit A** will govern and control; provided, however, if there is any conflict between any of the terms of this Agreement, including this **Exhibit A**, and the applicable State Contract (as defined in this Agreement), then the terms of the State Contract will govern and control.

The term "Provider," as it appears throughout this **Exhibit A**, shall refer to Delegated Entity.

I. STATE-REQUIRED TERMS

If there is any conflict between the terms of this Exhibit A and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this **Exhibit A** will govern and control; provided, however, if there is any conflict between any of the terms of this Agreement, including this **Exhibit A**, and the State Contract (as defined in the Agreement), 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 provider executing this Agreement, as identified on the first page of the Agreement.

1. **Illinois Medicaid Managed Care Required Provisions.** The following provisions are required in accordance with the State Contract.

3.4.2.1 Provider shall be bound by the terms and conditions of the State Contract that are appropriate to the services provided by Provider, including, but not limited to, the record keeping and audit provisions of the State Contract, such that the Department or Authorized Persons shall have the same rights to audit and inspect Provider as they have to audit and inspect Company (hereinafter "Contractor").

3.4.2.2 Contractor shall remain responsible for the performance of any of its responsibilities delegated to Provider or subcontractors.

3.4.2.3 Provider providing Covered Services for Contractor under this Agreement must be enrolled as providers in the Medicaid Program, if they are a Provider type that is required to enroll in the Medicaid Program to bill services on
a Fee-For-Service basis. Contractor shall not contract or subcontract with an ineligible person.

3.4.2.4 Contractor will report to the Department all entities that are sub-capitated or assume risk.

3.4.2.5 In satisfaction of the Lobbying Certification contained in Section 5.10 of the RFP related to the State Contract, Contractor certifies, to the best of Contractor's knowledge and belief, that no federally appropriated funds have been paid or will be paid by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. Furthermore, if any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Contractor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such Form is to be obtained at Contractor's request from the Agency/Buyer's Bureau of Fiscal Operations.

3.4.2.6 The Parties agree to comply with those Contractor Grievance and Appeal processes set forth in the Agreement; provided, further, Contractor shall, where applicable, amend the Agreement as soon as practicable after notification from the Department of any substantive change to such procedures.

3.4.2.7 Contractor will monitor the performance of all Providers and subcontractors on an ongoing basis, subject each Provider and subcontractor to formal review on a triennial basis, and, to the extent deficiencies or areas for improvement are identified during an informal or formal review, require that the Provider or subcontractor take appropriate corrective action.

3.4.2.8 Contractor retains the right to terminate this Agreement, and any provider agreement or subcontract, or impose other sanctions, if the performance of the Provider or subcontractor is inadequate in accordance with the terms of the Agreement.

3.4.2.9 That, except as permitted or required by the Illinois Department of Healthcare and Family Services (the "Department") in 89 Ill. Adm. Code 125 or the Department's Medical Program co-payment policy in effect at the time services are provided, neither Contractor nor its sub-contractors, Affiliated Providers (including Provider), or non-Affiliated Providers may seek or obtain funding through fees or charges to any Enrollee receiving Covered Services pursuant to the State Contract.

3.4.3 Any contract or subcontract between Contractor and a federally qualified health center ("FQHC") or a rural health clinic ("RHC") shall be executed in accordance with 1902(a)(13)(C) and 1903(m)(2)(A)(ix) of the Social Security Act, as amended by the Balanced Budget Act of 1997 and shall provide payment that is not less than the level and amount of payment which Contractor would make for the Covered Services if the services were furnished by a Provider which is not an FQHC or a RHC.

3.4.4 Prior to entering into a Provider agreement or subcontract, Contractor shall submit a disclosure statement to the Department specifying any Provider agreement or subcontract and Providers or subcontractors in which any of the following have a five percent (5%) or more financial interest: (1) Any Person also having a five percent (5%) or more financial interest in Contractor or its Affiliates as defined by 42 CFR Section 455.101 (**3.4.4.1**); (2) Any director, officer, trustee, partner or employee of Contractor or its Affiliates (**3.4.4.2**); or (3) Any member of the immediate family of any Person designated in (a) or (b) above (**3.4.4.3**).

3.4.4.4 Upon request by the Department, Contractor shall immediately submit copies of executed contracts and subcontracts.

2. Illinois State Regulatory Requirements. The following provisions are required by state law.

Provider's Insurance

The Section titled "Provider's Insurance" shall be deleted in its entirety and replaced with the following:

During the term of this Agreement, Provider agrees to procure and maintain such policies of general and professional liability and other 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 on or before the Effective Date of this Agreement. 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 the event that Provider is a Group, the Section titled "Provider's Insurance" shall also include the following paragraph:

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 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 on or before the Effective Date of this Agreement. 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.

Company Obligation to Pay for Covered Services

The following sentence shall be added to the Section of the Agreement titled "Company Obligation to Pay for Covered Services."

"To the extent, if any, that the compensation under certain HMO 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."

Coordination of Benefits

The following sentence shall be added to the end of the Section of the Agreement titled "Coordination of Benefits":

"With respect to HMO plans and as required by Ill. Admin. Code T. 50, 5421.50, to the extent Provider participates in capitated HMO Plans, Company acknowledges that in the event of Provider's insolvency, Company is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Members."

Holding Members Harmless

The section of the Agreement titled "Holding Members Harmless" shall be deleted in its entirety and replaced with the following:

With respect to HMO plans and as required by Ill. Admin. Code T. 50, 5421.50, if Provider participates in capitated HMO Plans agrees that in no event, including but not limited to nonpayment by HMO of amounts due Provider under this contract, insolvency of the HMO or any breach of this contract by the HMO, shall the Provider or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the enrollee, persons acting on the Member's behalf (other than the HMO), the employer or group contract holder for services provided pursuant to this contract; except for the payment of applicable co-payments or deductibles for services covered by the organization or fees for services not covered by the HMO. The requirements of this clause shall survive any termination of this contract for services rendered prior to such termination, regardless of the cause of such termination. The HMO's Members, the persons acting on the Member's behalf (other than the HMO), and the employer or group contract holder shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between the Provider and the Member, persons acting on the Member's behalf (other than the HMO) and the employer or group contract holder.

Unless otherwise required by Ill. Admin. Code T. 50, 5421.50 as set forth above, 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 or other supplemental charges 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.

Termination for Breach

The section of the Agreement titled "Termination for Breach" shall be deleted in its entirety and replaced with the following:

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 thirty (30) day period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 herein.

Obligation to Notify Members

The section of the Agreement titled "Obligation to Notify Members" shall be deleted in its entirety and replaced with the following:

Upon notice of termination of this Agreement or of a Plan, Company shall provide at least sixty (60) days' advance notice of the impending termination to Members of Plans currently under the treatment of Provider, or in the event of immediate termination, as soon as practicable after termination.

In the event that the Agreement does not contain a section titled "Obligation to Notify Members," then the following provision shall be added to such Agreement:

Obligation to Notify Members. Upon notice of termination of this Agreement, Company shall provide at least sixty (60) days' advance notice of the impending termination to Members currently under the treatment of Provider, or in the event of immediate termination, as soon as practicable after termination.

Compliance with 50 Ill. Adm. Code 5421.50(d)(1) & (2)

If Provider participates in a capitated HMO Plan, Provider shall submit, to Company, copies of its quarterly financial statements, which shall include Provider's balance sheet and statements of income and cash flow within 45 days after the end of each fiscal period. In addition, Provider shall submit, within 90 days after the end of Provider's fiscal year, copies of Provider's audited annual financial statements prepared in accordance with generally accepted accounting principles if available.

Provider agrees to fully cooperate with, and disclose all relevant information requested by, Company's actuaries for the preparation of such actuaries' opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.

By:_____

Printed Name:_____

Title:_____

Date:_____

Aetna Better Health Inc.
(an Illinois corporation)

By:_____

Printed Name: _____

Title: _____

Date:_____

Effective Date:_____

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

Aetna Better Health – IL
1 South Wacker Dr.
Chicago, Il, 60606
Attention: CEO

PRODUCT PARTICIPATION SCHEDULE

Participation under this Agreement will include the products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Those Medicaid Plans and programs offered by Company within the State of Illinois.

Individual Sites Regulatory Addendum – Exhibit A

MARYLAND REGULATORY ADDENDUM

MARYLAND MEDICAID REQUIREMENTS

Capitalized terms used and not otherwise defined in this Maryland Addendum (the "Addendum") shall have the meanings set forth in the Agreement. The Parties acknowledge that all requirements under this Addendum shall be met by MedSolutions, Inc., hereinafter "Delegated Entity" , when providing Medicaid services to Members in Maryland of Maryland Care Inc., doing business as Maryland Physicians Care (MPC). This Addendum shall be attached to, and constitute a part of, the Agreement. Any provisions of this Agreement, including this Addendum, which directly conflict with the terms and provisions of the State Contract will be deemed waived, unless such conflict may be resolved through construction or amendment as provided herein. In the event of any inconsistency between the terms of this Addendum and any other part of the Agreement, the terms of this Addendum shall govern and control as to Members in Maryland of Maryland Care Inc., doing business as Maryland Physicians Care, and all other terms and provisions of the Agreement not affected by this Addendum shall remain in full force and effect. The Parties agree as follows:

1. **Definitions.**

Department means the Department of Health and Mental Hygiene (DHMH) as defined by Health-General Article§15-101, et seq. Annotated Code of Maryland.

Medicaid includes the HealthChoice Program, Maryland Children's Health Insurance Program, and other Medicaid programs sponsored by DHMH for which MCOs may participate.

Medicaid Covered Persons or Members means individuals enrolled in the HealthChoice Program, Maryland Children's Health Insurance Program, Program and other Medicaid programs sponsored by DHMH for which MCOs may participate.

Contracted Services means services provided by Delegate Entity to Maryland Physicians Care specific to this Addendum to specifically include prior authorization determinations and utilization management services for specific radiology services and use of delegate's clinical criteria (approved by MPC annually).

Specific Radiology Services means high end radiology services as defined by MPC and MedSolutions.

2. **Subcontractual Relationships.** In accordance with the requirements of the Code of Maryland Regulations, as amended from time to time, Delegated Entity agrees it shall, and as applicable shall cause its subcontractors to:

2.1 Comply with all federal, State and local laws, rules, regulations, standards, and executive orders governing performance of duties under this Agreement, including without limitation 42 CFR § 438.214, which governs provider selection, as well as those designated within this Agreement.

2.2 As applicable to services provided and to the extent required by law, be subject to all of the requirements to which MPC is subject under its contract with the Department, and pursuant to the Department's regulations.

2.3 Release to MPC and to the Department, upon request, any information necessary for MPC to perform any of its contractual and regulatory obligations under its contract with the Department, including, but not limited to, its records, reporting, and quality assurance duties.

2.4 Keep its facilities and records open to inspection by MPC, the Department, and other government agencies, and shall be subject to all audits and inspections to the same extent that audits and inspections may be required of MPC under law or under its contract with the Department.

2.5 Furnish copies of Delegated Entity's services records pertaining to MPC's enrollees to MPC upon request for transfer to a subsequent provider in the event of a termination of this Agreement.

2.6 Look solely to MPC for compensation for contracted services provided to MPC's enrollees under the subcontract.

2.7 Submit evidence of Delegated Entity's professional liability coverage annually to MPC.

2.8 As applicable to services provided and to the extent required by law, become subject to all the requirements concerning audits and inspections by the Department and other government agencies that are imposed upon MPC by statute or regulation, or by its contract with the Department.

2.9 Become responsible for providing the specified health care services in compliance with all of the requirements imposed by COMAR §§ 10.09.62—10.09.75, as applicable to contracted services, including, but not limited to , quality assurance, medical records, and reporting requirements.

2.10 Deliver services under this Agreement in a manner that is consistent with the requirements of COMAR §§ 10.09.62—10.09.75 as applicable.

2.11 Hereby acknowledge that MPC may not knowingly enter into a sub-contractual relationship with providers who have been convicted of certain crimes or received certain sanctions as specified in §1128 of the Social Security Act, and represent and warrant that Delegated Entity has not been convicted of such crimes or received such sanctions.

2.12 Not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is the provider's patient for:

2.12.1 The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
2.12.2 Any information the enrollee needs in order to decide among all relevant treatment options;
2.12.3 The risks, benefits, and consequences of treatment or nontreatment; or
2.12.4 The enrollee's right to participate in decisions regarding the enrollee's own health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3. Oversight and Operations.

3.1. Delegated Entity has business continuity/disaster recovery plan in place that is consistent with industry best practices and will annually review, maintain and test such plans and provide any updates or changes to MPC upon request. In the event of any emergency performance interruption, Delegated Entity will implement the plans within two (2) days and provide MPC with written notice of such interruption and the resulting effects of such on the delivery of services.

3.2. Delegated Entity will support the following meetings on-site at MPC's corporate offices or by phone when appropriate: (i) MPC's Quarterly operational review meetings to review the clinical, operational and financial performance of the program; (ii) MPC Quarterly oversight review meetings (iii) Annual executive meetings; and (iv) Monthly meetings if requested by MPC. All

final meeting materials for such meetings will be provided by Delegated Entity to all meeting participants within 45 days of the end of a quarter or at least three (3) Business Days before the meeting, unless the required data is not yet available on Delegated Entity's applicable systems or as otherwise agreed to by the parties. Delegated Entity agrees that all regulatory and oversight reporting and data shall be provided by Delegated Entity in a reasonable timeframe as mutually agreed to by the parties for MPC to review and prepare reports for submission to the applicable regulatory agency.

3.3. All program communications involving members will be available at the 6th grade reading level or lower.

3.4. MPC (or a mutually agreeable designee) will have the right to audit on an annual basis or more frequently if necessary, with full cooperation of Delegated Entity and its subcontractors, the services and pricing to validate compliance with all program requirements and contractual guarantees including, but not limited to, and general contract, legal and regulatory compliance. MPC (or its designee) will have access to such data for up to three (3) years following termination or expiration of the Agreement for Services provided to MPC. Delegated Entity and its subcontractors, will retain the data for a period of ten (10) years following termination of the applicable agreement (Delegated Entity Services Agreement) for Services provided to MPC or for such other time as required by applicable Law. Audits will be subject to confidentiality provisions of the Agreement.

3.5. MPC (or its designee) will have access to the Delegated Entity's agreements with subcontractors, subject to confidentiality provisions of the Agreement, to confirm satisfactory performance of the services associated with the Agreement; provided, however, that MPC will have access to these documents only through a mutually agreeable third party.

3.6. All data and information obtained by Delegated Entity in connection with Delegated Entity services that relates to MPC and its customers, members, providers and benefit plans including, but not limited to, all eligibility and claims data, and any other Delegated Entity-generated data, information, reports or summaries derived there from, shall belong solely to MPC; and the Delegated Entity will not use, sell or disclose such MPC data (including de-identified data elements) for any purpose other than as required for the performance of Delegated Entity services without the prior written consent of MPC. As such, Delegated Entity will not sell or distribute any such MPC data for pecuniary gain, publicize such MPC data or produce, use or distribute written reports containing such MPC data.

4. Notwithstanding any other provision of this Agreement to the contrary, no termination of the Agreement, as it relates specifically to services provided to MPC, shall be effective without prior written notice to the Department. No assignment of this Agreement by Delegated Entity, as it relates specifically to services provided to MPC, shall be effective without prior written notice to the Department. The required provisions of Sections 2.1 and 2.2 of this Addendum supersedes and controls over any conflicting terms that appear in the Agreement as it relates specifically to services provided to MPC.

5. In accordance with the requirements of the Code of Maryland Regulations, as amended from time to time, Delegated Entity agrees that it shall adhere to the applicable terms and conditions of this Section 5 of this Addendum; provided that to the extent that the provisions of this Section 5 of this Addendum conflicts with any term of this Agreement, this Section 5 of this Addendum shall control.

5.1. Specific Terms:

5.1.1. Any notices required under this Agreement shall be delivered to MPC at: Maryland Physicians Care:

Attn: Chief Executive Officer
509 Progress Drive, Suite 117

Linthicum Heights, MD 21090

with a copy to:

Aetna Inc.
Attention: Law & Regulatory Affairs, RE6A
151 Farmington Avenue
Hartford, CT 06156

5.1.2. Insurance and Liability: Evidence of insurance coverage shall be provided to MPC annually for submission to DHMH, in accordance with COMAR 10.09.65.17(h).

5.2. Termination: No termination shall be effective without prior written notice to DHMH in accordance with COMAR 10.09.65.17.4. This Agreement may be terminated without cause by MPC, as to MPC, upon 90 days prior written notice to Delegated Entity.

5.3. Clarification of Definitions: The definitions set forth in COMAR 10.09.62.01 serve as the controlling definitions for terms set forth in this Attachment.

6. Pursuant to MPC's Managed Care Organization Healthchoice Provider Agreement with the Department, as it may be amended from time to time, Delegated Entity agrees that it shall:

6.1. Maintain adequate records sufficient to describe the nature and extent of all goods and services provided and rendered to MPC enrollees for a minimum of six (6) years, and to the extent not prohibited by law or obligation to provide certified copies of claims records and originals of business records upon request to the Department and/or its designee, the Medicaid Fraud Control Unit, the Insurance Fraud Division of the Maryland Insurance Administration, or any other authorized State or Federal agency, or as otherwise required by State or Federal law or regulation, or pursuant to subpoena or court order.

6.2. Permit the Department, the Maryland Insurance Administration, and/or the Department of Health and Human Services, or any of their respective designees to: (i) conduct review necessary to evaluate the quality, appropriateness, and timeliness of services performed through inspection, market conduct reviews or other means, including accessing Delegated Entity's facilities relevant to the review using enrollment cards and identities established in the manner specified by the Department, and (ii) inspect and audit financial records relevant to the services provided and as necessary to accomplish the intended audit, including reimbursement rates, and records relating to MPC's capacity to bear the risk of potential financial losses, as required by 42 C.F.R. Section 434.38.

7. **Administrative Service Provider Contract**: If an agreement between the Delegated Entity and MPC constitutes an Administrative Service Provider Agreement pursuant to Maryland Health General Annotated code section 19-713.2, Delegated Entity and MPC must comply with the controlling laws and regulations governing the Administrative Service Contract, including timely filing and maintaining any required registration as an Administrative Service Provider. The parties, having concluded that such requirements to not apply to the scope of services contemplated in the Agreement, agree to amend this Addendum to provide for compliance should the scope of services be modified.

8. **Survival.** The obligations set forth in this Addendum shall survive the termination or expiration of this Addendum until expiration services run-out period and MPC's receipt of all monthly reports and annual financial statements related to the term of this Addendum.

9. **Confidentiality.** The Addendum and all supporting documentation submitted in connection with the Addendum shall be treated as confidential and proprietary, and may not be disclosed except as otherwise required by applicable law.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.

By: _____

Printed Name: Phillip S. Clarke

Title: General Counsel

Date: 4.1.14

Maryland Care, Inc

By: _____

Printed Name: Cynthia M. Demarest

Title: CEO

Date: 3/19/14

Effective Date: 4/1/14

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

Maryland Physicians Care
Attention: CEO
509 Progress Drive
Suite 117
Linthicum, MD 21090

New Jersey Subcontractor Regulatory Addendum

This Regulatory Addendum is incorporated by reference into the Agreement.

If there is any conflict between the terms of this Exhibit A and any of the terms of this Agreement, the terms of this Exhibit A shall govern and control. For purposes of this Regulatory Addendum, the term "Subcontractor" shall mean the Subcontractor to this Agreement, as identified on the first page of the Agreement and the term "Company" and "Purchaser" shall mean Aetna Better Health, Inc., a New Jersey corporation.

"State Contract" means the State of New Jersey Department of Human Services, Division of Medical Assistance and Health Services and Aetna Better Health, Inc. Contract to Provide Services, entered into on _____, 201[_].

Capitalized terms not otherwise defined in this Agreement, or its attachments, shall have the meaning ascribed to them in the State Contract.

I. DMAHS Mandatory Terms

The Subcontractor agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions to the extent applicable to this Agreement:

A. SUBJECTION OF PROVIDER CONTRACT/SUBCONTRACT

This provider contract/subcontract shall be subject to the applicable material terms and conditions of the contract between the contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the contractor.

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

The provider/subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

C. APPROVAL OF PROVIDER CONTRACTS/SUBCONTRACTS AND AMENDMENTS

The provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

D. EFFECTIVE DATE

This provider contract/subcontract shall become effective only when the contractor's agreement with the State takes effect.

E. NON-RENEWAL/TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT

The provider/subcontractor understands that the contractor shall notify DMAHS at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the provider/subcontractor from participation in the contractor's network. If the termination was "for cause," the contractor's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless the contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

F. ENROLLEE-PROVIDER COMMUNICATIONS

1. The contractor shall not prohibit or restrict the provider/subcontractor from engaging in medical communications with the provider's/subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider/subcontractor and the provider's/subcontractor's patient. Providers/subcontractors shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractors shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in section F.1 shall be construed:

a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers/subcontractors and their patients;

or

b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontractor or to otherwise require the contractor to reimburse providers/subcontractors for benefits not covered.

G. RESTRICTION ON TERMINATION OF PROVIDER CONTRACT/ SUBCONTRACT BY CONTRACTOR

The contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the contractor's decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the contractor's decision; or because the provider/subcontractor discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the contractor or not, policy provisions of the contractor, or the provider/subcontractor's personal recommendation regarding selection of a health plan based on the provider/subcontractor's personal knowledge of the health needs of such patients.

2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the provider/subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT – STATE

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;

2. Takes any action that threatens the fiscal integrity of the Medicaid program;

3. Has its certification suspended or revoked by DOBI, DOH, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

4. Becomes insolvent or falls below minimum net worth requirements;

5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;

6. Materially breaches the provider contract/subcontract; or

7. Violates state or federal law, including laws involving fraud, waste, and abuse.

I. NON-DISCRIMINATION

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are "qualified individuals with a disability" covered by the provisions of the ADA. The contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

A "qualified individual with a disability" as defined pursuant to 42 U.S.C.§12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

The provider/subcontractor shall submit to Company a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that the provider/subcontractor meets ADA requirements to the best of the provider/subcontractor's knowledge. The provider/subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the provider/subcontractor to be in compliance with the ADA. Where applicable, the provider/subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4. The provider/subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1

through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.

6. Grievances. The provider/subcontractor agrees to forward to Company copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by the provider/subcontractor.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF THE CONTRACTOR'S INSOLVENCY AND TO HOLD ENROLLEES AND FORMER ENROLLEES HARMLESS

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the contractor or the state, insolvency of the contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in section 2.P.

3. The provider/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the contractor, and shall be construed to be for the benefit of the contractor or enrollees.

4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.

5. The provider/subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.

6. The provider/subcontractor shall comply with the prohibition against billing members contained in 42 CFR 438.106, N.J.S.A. 30:4D-6.c, and N.J.A.C. 10:74-8.7.01.

K. INSPECTION

The provider/subcontractor shall allow the New Jersey Department of Human Services, the U.S. Department of Health and Human Services (DHHS), and other authorized State agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the provider contract/subcontract, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by the provider/subcontractor pertaining to such services, at any time during normal business hours (and after business hours when deemed necessary by DHS or DHHS) at a New Jersey site designated by the State. Inspections may be unannounced for cause.

The subcontractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by the provider/subcontractor, prior to approval of their use for providing services to enrollees. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this provider contract/subcontract, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to enrollees. Upon request, at any time during the period of this provider contract/subcontract, the provider/subcontractor shall furnish any such record, or copy thereof, to the Department or the Department's External Review Organization within 30 days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.

The DMAHS, the MFD, or its designee, and the MFCU, shall have the right to inspect, evaluate, and audit all of the following documents in whatever form they are kept, related to this contract:
1. Financial records, including but not limited to tax returns, invoices, inventories, delivery receipts, Medicaid claims;

2. Medical records, including but not limited to medical charts, prescriptions, x-rays, treatment plans, medical administration records, records of the provision of activities of daily living, ambulance call reports;

3. Administrative documents, including but not limited to credentialing files, appointment books, prescription log books, correspondence of any kind with contractor, DMAHS, CMS, any other managed care contractor, Medicaid recipient, contracts with subcontractors, and contracts with billing service providers; and

4. All records required to be kept to fully disclose the extent of services provided to Medicaid recipients, pursuant to NJAC 10:49-9.8(b) (1).

L. RECORD MAINTENANCE

The provider/subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. RECORD RETENTION

The provider/subcontractor hereby agrees to maintain an appropriate recordkeeping system for services to enrollees. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary and make that information readily available to appropriate health professionals and the Department. Records must be retained for the later of:

1. Five (5) years from the date of service, or

2. Three (3) years after final payment is made under the provider contract/subcontract and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the contractor, the provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies

of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

N. DATA REPORTING

The provider/subcontractor agrees to provide all necessary information to enable the contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. DISCLOSURE

1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the contractor's agreement with the State.

2. The provider/subcontractor shall comply with financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.

3. The provider/subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A and B enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with the attached schedule.

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.

4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.

5. The provider/subcontractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the provider/subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subcontractor/provider.

R. CONFIDENTIALITY

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.4. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the contractor's plan that are eligible through the Division of Youth and Family Services, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department's prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the provider contract/subcontract, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within the provider's/subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.

5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, the provider/subcontractor is responsible for complying, at a minimum, with the following statues and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U.S.C. 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. CLINICAL LABORATORY IMPROVEMENT

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. FRAUD, WASTE, AND ABUSE

1. The provider/subcontractor agrees to assist the contractor as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.23) in the provision of health care services.

2. If the State has withheld payment and/or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 456.23 and NJAC 10:49-9.10(a), the contractor shall have the right to withhold payments from the provider/subcontractor and/or forward those payments to the State.

3. The contractor and its providers, and subcontractors, whether or not they are enrolled Medicaid providers, shall cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DOH, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. The contractor shall include language in its contracts with its providers and subcontractors, requiring cooperation, and stating that a failure to cooperate shall be grounds for termination of the contractor's agreement with the provider or subcontractor. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

4. MFD shall have the right to recover directly from providers and enrollees in the contractor's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with the contractor, but reported to DMAHS in the format that the contractor reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the contractor to withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by the contractor shall be sent to MFD from the contractor and reported to DMAHS in the format that the contractor reports its recoveries to DMAHS.

5. The contractor shall have the right to recover directly from providers and enrollees in the contractor's network for the audits and investigations the contractor solely conducts.

U. THIRD PARTY LIABILITY

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.

2. Except as provided in subsection 3. below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to the contractor.

3. In the following situations, the provider/subcontractor may bill the contractor first and then coordinate with the liable third party, unless the contractor has received prior approval from the State to take other action.

a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.

b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.

c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.

d. The claim is for a child who is in a DCP&P supported out of home placement.

e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.

4. If the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the contractor without having received a written denial from the third party.

5. Sharing of TPL Information by the Provider/Subcontractor.

a. The provider/subcontractor shall notify the contractor within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the contractor, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.

b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the provider's/subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee's diagnosis and the nature of the service provided to the enrollee.

c. The provider/subcontractor shall notify the contractor on no less than a weekly basis when it becomes aware of the death of one of its Medicaid enrollees age 55 or older, utilizing the "Combined Notification of Death and Estate Referral Form" located in subsection B.5.1 of the Appendix.

d. The provider/subcontractor agrees to cooperate with the contractor's and the State's efforts to maximize the collection of third party payments by providing to the contractor updates to the information required by this section.

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing and /or third party liability, is the contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i) , 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract), or NJAC 10:74-9.1; and

d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and

e. The protections afforded to enrollees under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

f. The provider has received no program payments from either DMAHS or the contractor for the service; or

g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the contractor's network; or

b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

II. Miscellaneous DMAHS Terms

A. Insurance. To the extent applicable, the Subcontractor must obtain appropriate insurance coverage, including professional malpractice insurance, comprehensive general liability insurance, and automobile liability insurance. The minimum coverage for malpractice insurance shall be $1,000,000 per incident/$3,000,000 aggregate. The Subcontractor agrees that any insurance obtained by the Subcontractor shall not limit the Subcontractor's indemnification of the State and enrollees.

B. Cooperation. The Subcontractor must cooperate and participate in the Purchaser's quality management and utilization management system, including credentialing/recredentialing; appointment standards; and enrollee and provider complaint and grievance system.

C. Equality of Access. To the extent applicable, the Subcontractor shall provide the same level of medical care and health service to DMAHS enrollees as it does to enrollees under private or group contracts.

D. Monitoring.

1. Monitoring by Purchaser. The responsibilities performed by the Subcontractor are monitored on an ongoing basis and the Purchaser is ultimately responsible to the HHS for the performance of all services. The Purchaser is responsible for ensuring that the performance of the Subcontractor is consistent with the State Contract. The Purchaser has the right to revoke this Agreement if the Subcontractor does not perform satisfactorily, subject to the termination provisions herein.

2. Monitoring/Enforcement by State. HHS may require the Purchaser to terminate the Agreement if performance is not consistent with the State Contract.

E. 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 part performs under this Agreement without prompt and timely written objection.

F. MacBride Principles Certification Form. The Subcontractor must execute the MacBride Principles Certification Form included in Exhibit B.

III. New Jersey Department of Banking and Insurance Required Terms The following terms and conditions apply only to this Agreement if it relates to the provision of health care services or supplies by the Subcontractor. These terms are not applicable if the Agreement pertains to purely administrative services provided by the Subcontractor on behalf of Company. The Subcontractor agrees that all contracts that the

Subcontractor has with providers in accordance with the terms of the Agreement shall specifically refer to and contain all of the provisions set forth in NJAC 11:24-15 and require that its providers comply with all of the terms and conditions set forth therein.

A. Licensure/Certification. The Subcontractor shall maintain appropriate licensure and certifications required in order to perform its obligations under this Agreement.

B. No Violation of Law. This Agreement shall not be interpreted to impose obligations or responsibilities upon a Subcontractor which requires 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.

C. Notice of Termination. To the extent applicable, if this Agreement between Company and Subcontractor is terminated by Company on any date other than the designated renewal date unless termination was made by mutual agreement of the parties, Company shall give Subcontractor at least ninety (90) days prior written notice of the termination and the opportunity to request a hearing in all instances except when the termination is based upon non-renewal of this Agreement, a determination of fraud, breach of contract by Subcontractor, sanctions by a State or Federal agency, or the opinion of Company's medical director that Subcontractor represents an imminent danger to a Member or the public health, safety and welfare. The notice of termination shall specify: (a) that the Subcontractor may request in writing from Company, within fifteen (15) days of receipt of the notice, a written reason for the termination unless such reason is already stated in the notice, (b) that the Subcontractor may request a hearing, and; (c) the procedures for exercising Subcontractor's right to a hearing. The Subcontractor's participation in the hearing process shall not be deemed an abrogation of the Subcontractor's legal rights.

D. Pricing Following Termination. To the extent applicable, the Subcontractor shall continue to provide services to members at the contract price following termination of this Agreement, in accordance with N.J.A.C. 11:24-3.5.

E. Secondary Contractors. To the extent Subcontractor is or acts as a secondary contractor (as defined in Section 11:24-1.2 of the New Jersey Administrative Code), Company is a third party beneficiary of the secondary contractor's contract(s) with the health care providers, and Subcontractor's contract(s) with health care providers shall provide that Company shall have privity of contract with the health care providers such that the Company shall have standing to enforce Subcontractor's contract(s) with the health care providers in the absence of enforcement by Subcontractor. All Subcontractor's agreements with health care providers shall be consistent with laws regarding confidentiality of information and with professional licensing standards, including, but not limited to, New Jersey Statutes Sections 45:14B-31 et seq. and 11:24-15.2(b-e) of the New Jersey Administrative Code. Such contracts shall include a provision whereby the provider is required to hold Members harmless for the cost of any service or supply covered by Company, subject to Section 11:24-15.2(b)(7)(i & ii), whether or not the provider believes the compensation received is adequate. Company reserves the right to enter into separate contracts directly with such health care providers, as set out in NJAC 11:24-15.2(g).

Notwithstanding the foregoing sentence, the rights of Company as a third party beneficiary and of privity of contract with respect to the Subcontractor's contracts with heath care providers in no way limit Subcontractor's obligations to enforce the terms of such contracts nor shall such rights be construed in any way to impose an obligation on Company to enforce such contracts.

IV. Pharmacy Subcontracts

If this Agreement is for the provision of pharmacy services or supplies by the Subcontractor than this Agreement must comply with N.J. Stat. 26:2J-4.7 and all the terms and conditions of the Agreement are subject to the provisions set forth in N.J.A.C. 11:24-18.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.

By:_____

Printed Name:_____

Title:_____

Date:_____

Aetna Better Health Inc.
(a New Jersey corporation)

By:_____

Printed Name: _____

Title:_____

Date:_____

Effective Date:_____

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

As of the date of execution of this Agreement, Company is not yet able to identify the "notices" address that will be in effect as of the Effective Date of this Agreement. The Parties understand and agree that, on or prior to the Effective Date of this Agreement, Company will provide Facility with such "notices" address by letter, newsletter, electronic mail or other media. Notwithstanding any other provision to the contrary, Company shall not be required to provide such address information by overnight delivery service with proof of receipt, or by certified mail return receipt requested.

EXHIBIT B

MACBRIDE PRINCIPLES CERTIFICATION FORM

COMPLETE THIS CERTIFICATION IN COMPLIANCE WITH MACBRIDE PRINCIPLES AND NORTHERN IRELAND ACT OF 1989

Pursuant to Public Law 1995, c.134, a contractor must complete the certification below by checking one of the two representations listed and signing where indicated.

I certify, pursuant to N.J.S.A. 52:34-12.2 that the entity for which I am authorized to contract:

____ has no ongoing business activities in Northern Ireland and does not maintain a physical presence therein through the operation of offices, plants, factories, or similar facilities, either directly or indirectly, through intermediaries, subsidiaries or affiliated companies over which it maintains effective control; or

____ will take lawful steps in good faith to conduct any business operations it has in Northern Ireland in accordance with the MacBride principles of nondiscrimination in employment as set forth in N.J.S.A. 52:18A-89.5 and in conformance with the United Kingdom's Fair Employment (Northern Ireland) Act of 1989, and permit independent monitoring of their compliance with those principles.
I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature: Date:
Print Name:

Title:

Firm Name:

PRODUCT PARTICIPATION SCHEDULE

Participation under this Agreement will include the products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Those Medicaid Plans and programs offered by Company within the State of New Jersey.
- Dual Eligible Plans and programs offered by Company within the State of New Jersey.

Individual Sites Regulatory Addendum – Exhibit A

NEW YORK (RISK)

NEW YORK STATE DEPARTMENT OF HEALTH
STANDARD CLAUSES
FOR MANAGED CARE PROVIDER/IPA CONTRACTS

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. DEFINITIONS FOR PURPOSES OF THIS APPENDIX

"Managed Care Organization" or " MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

B. GENERAL TERMS AND CONDITIONS

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6) (e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least thirty (30) days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider

that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

4. As applicable, Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the Provider at least thirty (30) days in advance of implementation, including but not limited to:

    - quality improvement/management;
    - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
    - member grievances; and
    - provider credentialing.

5. The Provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. Intentionally Left Blank.

7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.

8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007 and Chapter 237 of the Laws of 2009 with all amendments thereto.

9. To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:

    a. the MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;

    b. the Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA's performance; and

    c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.

    d. The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to

her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.

e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

f. The Provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

g. The Provider or IPA agrees , pursuant to 31 U.S.C. § 1352 and CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The Provider or IPA agrees to complete and submit the "Certification Regarding Lobbying," Exhibit A-1 attached hereto and incorporated herein, if this Agreement exceeds $100,000.

If any funds other than Federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

h. The Provider agrees to disclose to MCO on an ongoing basis, any managing employee that has been convicted of a misdemeanor or felony related to the person's involvement in any program under Medicare, Medicaid or a Title XX services program (Block grant programs)

i. The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals posted by the OMIG on its Website.

j. The Provider agrees to disclose to MCO complete ownership, control, and relationship information.

k. Provider agrees to obtain for MCO ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12 month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to MCO within 35 days of such request.

10. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

11. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply with all applicable requirements of

the Health Insurance Portability and Accountability Act; the HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law § 33.13.

C. PAYMENT / RISK ARRANGEMENTS

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law § 4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made

directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

5. The parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member's inpatient hospital discharge, consistent with Public Health Law § 4903.

D. RECORDS ACCESS

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements ("QARR")), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

2. When such records pertain to Medicaid or Family Health Plus reimbursable services the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. TERMINATION AND TRANSITION

1. Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that

termination, by the MCO may be effected on less than 45 days notice provided the MCO demonstrates to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days notice of its decision to not renew this Agreement.

3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA's Provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA's providers agree, that the IPA providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term "provider" shall include the IPA and the IPA's contracted providers if this Agreement is between the MCO and an IPA. This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the Provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

F. ARBITRATION

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

G. IPA-SPECIFIC PROVISIONS

1. Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.

EXHIBIT A-1 TO EXHIBIT A
CERTIFICATION REGARDING LOBBYING

NEW YORK

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: _____

TITLE: _____

ORGANIZATION: _____

NAME: (Please Print) _____

SIGNATURE: _____

EXHIBIT B to EXHIBIT A
STATE COMPLIANCE ADDENDUM

NEW YORK (RISK)

1. Participation in New York Contracts. Subject to and in accordance with the terms and conditions of the Agreement, including this Exhibit, IPA and Participating IPA Providers shall participate in Plans offered or administered by Company in New York.

2. Additional Definitions.

   a. "**Emergency Medical Condition**" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

   b. "**Emergency Services**" means health care procedures, treatments or services needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs or alcohol.

   c. "**Medically Necessary**" or "**Medical Necessity**" means, with respect to health care items or services, items and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

   d. "**Post-Stabilization Care Services**" means covered services, related to an Emergency Medical Condition, that are provided after a Member is stabilized in order to maintain the stabilized condition, or to improve or resolve the Member's condition.

3. Emergency Services. Participating IPA Providers shall not be required to seek prior authorization for Emergency Services before the Member has been stabilized. Once a Member who receives Emergency Services is stabilized, the Participating IPA Provider shall seek prior authorization for Post-Stabilization Care Services for the Member in accordance with the provider manual.

4. Deficit Reduction Act. In accordance with Section 6032 of the Deficit Reduction Act of 2005 ("DRA"), IPA and Participating IPA Providers shall comply with Company's fraud and abuse prevention policy, as revised from time to time by Company. IPA shall make available to all employees and agents, and, to the extent required by DRA, its contractors, including but not limited to subcontracted providers, a copy of the Company fraud and abuse prevention policy, including specific discussion of the provisions of the Company fraud and abuse prevention policy in an employee handbook, if such agent or provider has an employee handbook.

   Upon request from Company, IPA and Participating IPA Providers agree to submit to Company a statement certifying that IPA and Participating IPA Providers comply with all applicable requirements, Federal and State, associated with the Company fraud and abuse prevention policy and the DRA. IPA and Participating IPA Providers shall cooperate fully with Company in any examination of the implementation of the Company's fraud and abuse prevention policy and shall provide any and all assistance requested by Company, CMS, the NY State Departments of Health or Social Services, and/or any law enforcement agency or any prosecutorial agency in the investigation and prosecution of fraud and abuse and related crimes.

5. Physician Incentive Plan Programs. The Parties shall comply with the requirements of the physician incentive plan (PIP) regulations contained in 42 C.F.R. § 438.6(h), 42 C.F.R. §§ 422.208 and 422.210. No specific payment will be made directly or indirectly as an inducement to reduce or limit medically necessary services furnished to a Member. Participating IPA Providers shall provide any physician incentive plan information in an accurate and timely manner to Company in the format requested by the New York State Department of Health. As applicable, IPA agrees to incorporate the requirements of the PIP regulations and this provision into its agreements with any persons/entities for the provision of services under this Agreement.

6. Continuation of Treatment Post-Termination. In accordance with New York State Public Health Law § 4403.6(e), upon termination or non-renewal of this Agreement, IPA and Participating IPA Providers shall allow Members to continue an ongoing course of treatment with Participating IPA Providers during a transitional period of (a) up to 90 days from the date of notice to the Member of the termination or non-renewal; or (b) if the Member has entered the second trimester of pregnancy at the time of termination or non-renewal, for a transitional period that includes the provision of post-partum care directly related to the delivery. IPA and Participating IPA Providers shall continue to accept the rates set forth in this Agreement for such transitional care services and to adhere to Company's quality assurance and all policy and procedure requirements.

7. Deemed Credentialed. If a Participating IPA Provider is a group practice, then any newly-licensed health care professional, or health care professional who has recently relocated to New York State from another State, is neither approved nor declined within 90 days of submitting a completed application packet for credentialing, the health care professional shall be deemed provisionally credentialed in accordance with New York State Public Health Law §4406-D.

8. Prompt Payment. The Parties shall comply with New York State Insurance Law § 3224-a. Except for fraud or where the obligation of Company is not reasonably clear, electronically submitted claims must be paid within 30 days of receipt of the claim or bill for services rendered, and claims submitted on paper or through fax must be paid within 45 days of receipt of the claim or bill for services rendered. Otherwise, Company shall deny the claim or ask for additional information within 30 days of receipt of the claim or bill for services rendered.

9. Intentionally Left Blank.

10. Overpayment. The Parties shall comply with New York State Insurance Law § 3224-b, which requires that Company provide Participating IPA Providers 30 days advance written notice before Company engages in additional overpayment recovery efforts seeking recovery of overpayments, other than duplicate payments. Such notice shall state the patient name, service date, payment amount, proposed adjustment and provide a reasonably specific explanation of the proposed adjustment. IPA or Participating IPA Providers may challenge any overpayment recovery pursuant to Company's policies and procedures, provided such challenge sets forth the specific grounds on which Participating IPA Provider is challenging the overpayment recovery.

11. Insurance. Participating IPA Providers that are chiropractors, physical, occupational, and speech therapists shall maintain professional liability insurance in an amount not less than $1,000,000 per occurrence and $3,000,000 in the aggregate.

12. Permitted Deductibles. Any reference in the Agreement to Deductibles means "Permitted Deductibles," which include only those deductibles associated with a point of sale contract or a high deductible health plan approved by the New York State Department of Health and the New York State Department of Financial Services.

EXHIBIT C TO EXHIBIT A

GOVERNMENT PROGRAMS ADDENDUM

NEW YORK

In addition to IPA's obligations under the Agreement, IPA agrees to abide by all applicable provisions of the contracts between Company and Government Sponsors and to fulfill IPA obligations hereunder in a manner consistent with Company's obligations under the Government Contracts. As used in this Exhibit, the term "IPA" includes "Participating IPA Providers". IPA's compliance specifically includes the following:

1. Application. IPA acknowledges and agrees that all provisions of this Addendum and of the Agreement shall apply equally to any employees, independent contractors and subcontractors of IPA who provide or may provide Covered Services to Members, and IPA represents and warrants that IPA shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply with this Addendum and the Agreement and all applicable laws and regulations, and perform all requirements applicable to Medicare and Medicaid programs. Company and IPA agree, and IPA shall require Participating IPA Providers to agree, that any services or other activity performed by IPA, Participating IPA Providers, or any first tier, downstream, or related entity in accordance with a contract or written agreement must be consistent with and comply with Company's contractual obligations.

2. Patient Confidentiality; Accuracy of Records. IPA shall be bound by any patient confidentiality provisions set forth in Company's policies and procedures, as well as federal and state laws and regulations and the provisions of the Government Contracts regarding confidentiality and disclosure of medical records or other health or enrollment information pertaining to Members. Without limiting the generality of the foregoing, IPA agrees to: (i) safeguard the privacy of all Member medical records and ensure that copies of or information from such records are released only to authorized individuals; (ii) release such records only in accordance with applicable federal or state laws or pursuant to court orders or subpoenas; (iii) maintain all such records in an accurate and timely manner; and (iv) ensure timely access by Members to records and information that pertain to them.

3. Payment. This paragraph 3 applies only if payment timeframes are not specified elsewhere in the Agreement: Company agrees to pay IPA for Covered Services rendered to Members within forty-five (45) calendar days of actual receipt by Company of a Clean Claim. Payments for non-capitated Covered Services rendered to Members are subject to any and all valid and applicable laws related to claims payment. With respect to Medicare and Medicaid Members, IPA acknowledges that compensation under the Agreement for such Members constitutes receipt of federal funds. IPA shall pay on a timely basis all employees, independent contractors and subcontractors who render Covered Services to Members for which IPA is financially responsible pursuant to the Agreement.

4. Hold Harmless. IPA acknowledges and agrees that in no event, including but not limited to the insolvency of Company, breach of the Agreement and/or non-payment for services by Company, shall IPA bill or seek compensation from or assert any legal action against Members or persons acting on behalf of Members for payment of any fees that are the legal obligation of Company. This provision shall not prohibit IPA from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the Evidence of Coverage, or fees for non-Covered Services delivered on a fee-for-service basis to a Member provided that IPA shall have advised the Member in writing that the service is not a Covered Service and of the Member's liability therefore prior to providing the service.

5. Dual Eligibles Hold Harmless. IPA acknowledges and agrees that Members eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Company will not impose cost-sharing that exceeds the amount of cost sharing that would be permitted with respect to the individual under Medicaid if the individual were not a Member. IPA will accept Company payment as payment in full or bill the appropriate State source. Medicare Part A and B services for FIDA members are provided at zero cost share to the Member, and IPA and providers may only bill company for such services.

6. Compliance. IPA shall comply with all applicable state and federal laws, rules and regulations governing the Government Programs and applicable state and federal guidance and instructions, and with Company's policies and procedures. IPA, Participating IPA Providers, and any related entity, contractor, or subcontractor of IPA or Participating IPA Providers must comply with all applicable Medicare laws, regulations and CMS instructions.

7. Credentialing. The credentials of medical professionals affiliated with IPA will be reviewed by Company in accordance with Company's polices as stated in the Agreement. If such credentialing process has been delegated to IPA as a part of this Agreement or in a separate Agreement, the credentialing process will be reviewed and approved by Company and Company shall audit the credentialing process on an ongoing basis. If Company has delegated a selection of providers, contractors, or subcontractors, Company shall retain the right to approve, suspend or terminate any arrangement with a provider, contractor or subcontractor.

8. Records/Audits/Access. IPA shall permit audits and inspection by Government Sponsors, including but not limited to the United States Department of Health and Human Services, the Comptroller General of the United States, CMS and/or their designees regarding any pertinent contracts, books, documents, papers and records (including medical records) (collectively, "Books and Records") involving or relating to IPA's provision of services to Members. All such Books and Records shall be retained and made available by IPA for a period of ten (10) years from the termination of the applicable Government Contract or ten (10) years from the date of completion of any audit or in certain instances described in applicable Laws and regulations, for periods in excess of ten (10) years, if appropriate.

9. Accountability. IPA acknowledges that Company oversees and is accountable to Government Sponsor for any functions and responsibilities set forth in the regulations governing the Government Programs. IPA further acknowledges and agrees that pursuant to applicable Laws and regulations, Company or its designees will monitor IPA's performance hereunder and that Company and/or Government Sponsor shall have the right to terminate the Agreement and IPA's participation in the Government Contract if IPA does not perform satisfactorily hereunder.

10. Delegation.

10.1 Any delegation of functions hereunder shall be in accordance with applicable delegation requirements set forth in applicable Laws. Company shall monitor any delegated functions and shall be ultimately responsible for the performance of all delegated functions.

10.2 If Company has delegated the selection of the providers, contractors, or subcontractors under this Agreement, Company retains the right to approve, suspend, or terminate any such arrangement.

10.3 If any of Company's activities or responsibilities pursuant to its contract with CMS are delegated, the following requirements shall apply:

10.3.1 Company may revoke the delegated activities and reporting requirements in instances where CMS or Company determines that the parties performing the delegated functions have not performed satisfactorily;

10.3.2 Company shall monitor the performance of the delegated functions on an ongoing basis; and

10.3.3 The credentials of medical professionals affiliated with the parties performing the delegated functions will either: (1) be reviewed by Company or (2) the credentialing process will be reviewed and approved by Company and Company will audit the credentialing process on an ongoing basis.

11. Reporting Requirements; Policies and Procedures. IPA acknowledges that Company is subject to reporting requirements specified in the applicable Law and regulations. In furtherance of any such applicable reporting requirements, IPA shall comply with all data and reporting requirements of Company. IPA shall also comply with all other policies and procedures of Company.

12. Continued Care. IPA agrees that: (i) Covered Services provided to Members hereunder shall continue for all members for the duration of the Government Contract period for which payments have been made to Company; and (ii) in the event of Company insolvency or termination of the Government Contract for any reason, Covered Services shall continue until the date of discharge for any Member confined in an inpatient IPA on the effective date of insolvency or termination.

13. Fraud, Waste and Abuse Compliance. IPA shall fully comply and cooperate with training and education given as part of Company's compliance plan to detect, correct and prevent fraud, waste, and abuse. IPA shall maintain procedures to voluntarily self-report to Government Sponsors and Company potential fraud or misconduct related to the provision of Covered Services to Members. Such procedures shall be submitted to Company on or before the date of execution of this Agreement and thereafter upon request, and shall be subject to audit by Company.

14. Risk Adjustment Data. For purposes of this Section 13, "risk adjustment data" shall have the meaning set forth in 42 C.F.R. Section 422.310(a), as may be amended from time to time. Company may be required to obtain risk adjustment data from IPA for Members, and IPA agrees to provide complete and accurate risk adjustment data to Company for Members that conforms to all standards and requirements set forth in applicable laws, rules and regulations and/or CMS instructions that apply to risk adjustment data. IPA certifies, based on best knowledge, information and belief, that any risk adjustment data that IPA submits to Company for Members is accurate, complete and truthful. IPA agrees to immediately notify Company if any risk adjustment data that was submitted to Company for Members is erroneous, and follow procedures established by Company to correct erroneous risk adjustment data to ensure Company's compliance with applicable laws, rules and regulations and CMS instructions.

IPA further agrees to maintain accurate, legible and complete medical record documentation for all risk adjustment data submitted to Company for Members in a format that meets all standards and requirements set forth in applicable laws, rules, regulations and/or CMS instructions, and allows any federal governmental authorities with jurisdiction or their designees ("Government Officials") to: (1) confirm that the appropriate diagnoses codes and level of specificity are documented ; (2) verify the date of service is documented and within the risk adjustment data collection period; and (3) confirm that the appropriate IPA provider's signature and credentials are present ("Medical Records").

IPA 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 risk adjustment data ("Audit Data"). IPA 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 CMS conducts a review that includes the validation of risk adjustment data submitted by IPA, Company will submit to IPA a copy of the CMS written notice of such review, along with a written request from Company for Audit Data.

15. Notice. IPA agrees to immediately notify Company in the event that IPA, any participating provider, or any of IPA's employees, contractors, subcontractors, agents or any other individual or entities that assist or are involved in IPA's performance of services for under the Agreement ("IPA Related Parties") are or become disbarred, excluded, suspended, or otherwise determined to be ineligible to participate in a federal health care program. At a minimum, IPA agrees to review the Department of Health and Human Services Office of Inspector General ("OIG") and General Service Administrative ("GSA") exclusion lists ("Exclusion Lists") on an annual basis (unless more frequently required under applicable laws, rules and/or regulations) to ensure that IPA Related Parties are not included on the Exclusion Lists. IPA shall not employ or contract with, with or without compensation, any individual or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in a federal health care program. IPA agrees that if a IPA Related Party appears on an Exclusion List and/or is excluded from participation in any federal health care program, IPA will immediately remove the IPA Related Party from any work related directly or indirectly to services under this agreement and take all corrective actions required under applicable laws, rules or regulations. Company may immediately terminate or suspend the Agreement upon notice to IPA, at Company's sole discretion at any time if IPA is debarred, sanctioned or suspended

from participation in any federal health care program, including, but not limited to, the Medicare or Medicaid programs.

16. Offshoring. In no event shall IPA, 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"). IPA further agrees that IPA 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 IPA with prior written approval to use an Offshore Entity to perform any services for Plans, IPA shall take all steps necessary to ensure that: (a) Offshore Entity complies with the requirements of this Agreement and any related Addendum, and (b) IPA 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 IPA, without Company's prior written approval, provide Protected Health Information (as that term is defined below) received from, or created or received by IPA 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.

17. Interpretation. In the event of any inconsistency between this and the Agreement, the parties agree that the terms of this Exhibit C shall control with respect to Government Programs services.

18. Cultural Competency. IPA must, and will require Participating IPA Providers to, provide services in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

19. Amendment. Company may amend this Exhibit C to comply with applicable law or regulation, any Government Program requirements or any order or directive of any governmental agency, without the consent of IPA, and this Exhibit C 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.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.	**Aetna Better Health Inc.** **(a New York corporation)**
By:_____	By:_____
Printed Name:_____	Printed Name: _____
Title:_____	Title: _____
Date:_____	Date:_____
	Effective Date:_____

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

Aetna Better Health of New York
55 West 125th Street
Suite 1300
New York, NY 10027

PRODUCT PARTICIPATION SCHEDULE

Participation under this Agreement will include the products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Those New York Medicaid Plans and programs offered by Aetna Better Health Inc., a New York corporation, within the State of New York.
- Those New York Dual Eligible Plans and programs offered by Aetna Better Health Inc., a New York corporation, within the State of New York.

Individual Sites Regulatory Addendum – Exhibit A
OHIO (Risk)

This Addendum will supplement the Base Contract between Aetna Medicaid Administrators, LLC and its Affiliates., and MedSolutions, Inc., a Tennessee corporation with its principal place of business in Franklin, TN effective _____ **[Date to be completed by Company]** and will run concurrently with the terms of the Agreement. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members.

ADDENDUM DEFINITIONS

Base Contract also known as **Agreement** means the contract between the MCP and the Provider.

MCP means a Medicaid managed care plan that has entered into a provider agreement to serve Medicaid consumers, which may include consumers enrolled in Integrated Care Delivery System (ICDS) Plans.

Medicaid means medical assistance provided under a state plan approved under Title XIX of the Social Security Act.

Member means a Medicaid recipient enrolled under the care management system pursuant to ORC 5111.16.

OAC means the Ohio Administrative Code.

ORC means the Ohio Revised Code.

ODJFS means the Ohio Department of Job and Family Services.

Provider means a hospital, health care facility, physician, dentist, pharmacy or otherwise licensed, certified, or other appropriate individual or entity, which is authorized to or may be entitled to reimbursement for health care services rendered to an MCP's member.

ADDENDUM PROVISIONS

The provisions of this Medicaid Addendum supersede any language to the contrary which may appear elsewhere in the Base Contract.

Participating providers providing health care services to Aetna Better Health Inc.'s members enrolled pursuant to a Medicaid Agreement agree to abide by all of the following specific terms:

1. Provider agrees that with the exception of any member co-payments the MCP has elected to implement in accordance with OAC rule 5101:3-26-12, the MCP's payment constitutes payment in full for any covered service and will not charge the member or ODJFS any co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise. This agreement does not prohibit Nursing Facilities (NFs) from collecting patient liability payments from members as specified in OAC rule 5101: 1-39-24 or Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) from submitting claims for supplemental payments to ODJFS as specified in OAC rules 5101:3-28-07 and 5101:3-16-05.

    A. MCP shall notify the provider whether MCP has elected to implement any member co-payments and if applicable under what circumstances member co-payments will be imposed in accordance with OAC rule 5101:3-26-12.

    B. Provider agrees that member notification regarding any applicable co-payment amounts must be carried out in accordance with OAC rule 5101:3-26-12.

2. Provider agrees not to hold liable ODJFS and the member in the event that the MCP cannot or will not pay for covered services performed by the provider pursuant to the Base Contract with the exception that:

   A. FQHCs and RHCs may be reimbursed by ODJFS in the event of MCP insolvency pursuant to Section 1902(bb) of the Social Security Act,

   B. The provider may bill the member when the MCP has denied prior authorization or referral for the services and the following conditions are met:

      i. The member was notified by the provider of the financial liability in advance of service delivery;

      ii. The notification by the provider was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose; and

      iii. The notification is dated and signed by the member.

3. Provider agrees to cooperate with the MCP's quality assessment and performance improvement (QAPI) program in all the MCP's provider subcontracts and employment agreements for physician and non-physician providers.

4. The MCP shall disseminate written policies that include detailed information about the False Claims Act and other provisions named in 42 U.S.C. Section 1396a(a)(68), any related State laws pertaining to civil or criminal penalties, whistleblower protections under such laws, as well as the MCP's policies and procedures for detecting and preventing fraud, waste and abuse; and the provider agrees to abide by the MCP's written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.

5. Provider agrees to cooperate with the ODJFS external quality review as described in OAC Division 5101:3, including rule 5101:3-26-07.

6. The terms of the Base Contract relating to the beginning date and expiration date or automatic renewal clause, as well as the applicable methods of extension, renegotiation and termination apply to this Addendum.

7. Notwithstanding item 6 of this Addendum, the MCP must give the provider at least sixty days prior notice for the nonrenewal or termination of the Base Contract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the Base Contract be terminated sooner.

8. Notwithstanding item 6 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:

   A. The provider gives the MCP at least sixty days prior notice for the nonrenewal or termination of the Base Contract. The effective date for the nonrenewal or termination must be the last day of the month; or

   B. ODJFS has proposed action in accordance with OAC Division 5101:3, including rule 5101:3-26-10(G), regardless of whether the action is appealed. The provider's nonrenewal or termination notice must be received by the MCP within fifteen working days prior to the end of the month in which the provider is proposing nonrenewal or termination. If the notice is not received by this date, the provider must extend the nonrenewal or termination date to the last day of the subsequent month

9. The procedures to be employed upon the ending, nonrenewal, or termination specified in the Base Contract, apply to this Addendum including an agreement to promptly supply all records necessary for the settlement of outstanding claims.

10. Notwithstanding Items 7 and 8 of this Addendum, in the event of a hospital provider's proposed non-renewal or termination of the Base Contract, the hospital provider agrees to notify in writing all providers who have admitting privileges at the hospital of the impending non-renewal or termination of the Base Contract and the last date the hospital will provide services to members under the Base Contract. This notice must be sent at least forty-five days prior to the effective date of the proposed non-renewal or termination. If the hospital provider issues less than forty-five days prior notice to the MCP, the notice to providers who have admitting privileges at the hospital must be sent within one working day of the hospital provider issuing notice of non-renewal or termination of the Base Contract.

11. Provider agrees to release to the MCP any information necessary for the MCP to perform any of its obligations under the ODJFS provider agreement, including but not limited to compliance with reporting and quality assurance requirements. Provider agrees the released information will be shared with ODJFS upon request to the MCP.

12. Provider must supply, upon request, the business transaction information required under 42 C.F.R. 455.105.

13. Provider and all employees of the provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the Base Contract and provider and all employees of the provider have not been excluded from participating in federally funded health care programs.

14. If the provider is a Medicaid provider, provider must meet the qualifications specified in OAC Division 5101:3, including rule 5101:3-26-05(C).

15. All laboratory testing sites providing services to members must have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or a certificate of registration along with a CLIA identification number.

16. Home health providers must meet the eligible provider requirements specified in OAC rule Chapter 5101:3-12 and comply with the requirements for home care dependent adults as specified in section 121.36 of the Ohio Revised Code.

17. Provider agrees to serve members through the last day the Base Contract is in effect.

18. If the provider is a third party administrator (TPA), the provider agrees to include all elements of OAC rule 5101:3-26-05(D) in its subcontracts and will ensure that its subcontractors will forward information to ODJFS as requested.

19. Provider agrees to provide services as enumerated in **Attachment B** of this Addendum (within the provider's scope of practice).

20. Provider shall be compensated pursuant to the method and in the amounts specified the Services and Compensation Schedule and the **Program Participation Schedule** of the Agreement.

21. Any amendment to the Attachment B and (Schedule, Exhibit, or Appendix) specified in items 19 or 20 of the addendum must be agreed to in writing by both parties.

22. If provider is a primary care provider (PCP), provider agrees to participate in the care coordination requirements outlined in OAC Division 5101:3, including rule 5101:3-26-03.1.

23. If provider is a hospital or hospital system, the Addendum must include the completed ODJFS Hospital Services Form, Attachment C of this addendum, which specifies which services of the hospital are included in the Base Contract.

24. MCP agrees not to prohibit, or otherwise restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

    A. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

    B. Any information the member needs in order to decide among all relevant treatment options.

    C. The risks, benefits, and consequences of treatment versus non-treatment.

    D. 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.

25. Provider agrees in providing health care services to members to identify and where indicated arrange, pursuant to the mutually agreed upon procedures between the MCP and provider for the following at no cost to the member:

    A. Sign language services.

    B. Oral interpretation and oral translation services.

26. MCP agrees to fulfill the provider's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the provider bills a member due to the MCP's denial of payment of a Medicaid service, as specified in OAC Division 5101:3 including rule 5101:3-26-08.4, utilizing the procedures and forms as specified in OAC rule 5101:6-2-35.

27. Provider agrees to contact the MCP's designated twenty-four-hour post-stabilization services phone line to request authorization to provide post-stabilization services in accordance with OAC Division 5101:3, including rule 5101:3-26-03(G).

28. Provider agrees not to identify the addressee as a Medicaid consumer on the outside of the envelope when contacting members by mail.

29. Provider agrees not to bill members for missed appointments.

30. Provider shall not discriminate in the delivery of services based on the member's race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

31. Provider, in performance of the subcontract or in the hiring of any employees for the performance of services under the contract, shall not by reason of race, color, religion, gender, sexual orientation, age disability, national origin, military status, genetic information, health status or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

32. Provider shall not in any manner discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the subcontract on account of race, color, religion, gender, sexual orientation, age

disability, national origin, military status, genetic information, health status, or ancestry.

33. Provider shall be bound by the same standards of confidentiality which apply to ODJFS and the state of Ohio as described in OAC rule 5101:1-1-03 and 45 CFR Parts 160 and 164, including standards for unauthorized uses of or disclosures of protected health information (PHI).

34. Provider agrees that their applicable facilities and records will be open to inspection by the MCP, ODJFS or its designee, or other entities as specified in OAC rule 5101:3-26-06.

35. Provider agrees that the Base Contract and Addendum are governed by, and are construed in accordance with all applicable laws, regulations, and contractual obligations of the MCP.

    A. ODJFS will notify the MCP and the MCP shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCP.

    B. This Addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.

    C. The MCP shall notify the provider of all applicable contractual obligations.

36. Provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC rule 5101:3-26.

37. Provider must retain and agrees to allow the MCP access to all member medical records for a period of not less than six years from the date of service or until any audit initiated within the six year period is completed and allow access to all record keeping, audits, financial records, and medical records to ODJFS or its designee or other entities as specified in OAC rule 5101:3-26-06.

38. Provider agrees to make patient medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the patient.

The Ohio Department of Job and Family Services permit changes to Attachments A and/or B by mutual written agreement of both parties and without renegotiation of the Base Contract or this Addendum.

Aetna Better Health Inc. (Ohio)	**MedSolutions, Inc.**
_____	_____
By	**By**
_____	_____
Printed Name	**Printed Name**
_____	_____
Title	**Title**
_____	_____
Date	**Date**
	_____
	EffectiveDate

Attachment A to Exhibit A

[NON-Primary Care Providers Only]

List all non-PCP names that have been contracted with to provide services to Medicaid Members.

PRACTICE SITE	PROVIDER NAME	SPECIALTY
1) (Practice Name) (Address) (City Zip Code) (County)	n/a	
2) (Practice Name) (Address) (City Zip Code) (County)		
3) (Practice Name) (Address) (City Zip Code) (County)		

If the practice has more than three locations or more than (5) providers at a location, please provide the requested information in a document titled "Attachment A". If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3) and the last page must be signed by the provider and the MCP.

Aetna Better Health Inc. (Ohio)

_____
By

_____
Printed Name

_____
Title

_____
Date

MedSolutions, Inc.

_____
By

_____
Printed Name

_____
Title

_____
Date

Attachment B to Exhibit A

Provider agrees to provide services as enumerated below (specify below):

- ☐ Ambulance transportation
- ☐ Ambulatory Surgery Center
- ☐ Advanced practice nurse services (specify: _____)
- ☐ Chiropractic services
- ☐ Dental services
- ☐ Durable medical equipment (DME)
- ☐ Emergency Services
- ☐ Family planning services and supplies
- ☐ Federally Qualified Health Center services
- ☐ Home health services/Private Duty Nursing
- ☐ Hospice care
- ☐ Medical Imaging
- ☐ Inpatient hospital services
- ☐ Laboratory services
- ☐ Mental health and/or substance abuse services
- ☐ Nursing facility services
- ☐ Obstetrical and/or gynecological services
- ☐ Ophthalmology services
- ☐ Outpatient hospital services
- ☐ Physical and occupational therapy
- ☐ Podiatry services
- ☐ Pharmacy
- ☐ Physician services
- ☐ Primary care provider services
- ☐ Renal dialysis
- ☐ Rural Health Clinic services
- ☐ Specialty physician services, Specify (e.g., cardiology, allergy, etc): _____
- ☐ Speech and hearing services
- ☐ Vision (optical) services, including eyeglasses
- ☐ Other

Community Behavioral Health Services (included only in the ICDS benefit package)

- ☐ Pharmacological Management
- ☐ Behavioral Health Assessment
- ☐ Behavioral Health Counseling and Therapy
- ☐ Crisis Intervention
- ☐ Partial Hospitalization
- ☐ Community Psychiatric Support Treatment
- ☐ Ambulatory Detox
- ☐ Targeted Case Management for AOD
- ☐ Intensive Outpatient
- ☐ Laboratory urinalysis
- ☐ Med –Somatic
- ☐ Methadone Administration

Home and Community Based Services (included only in the ICDS benefit package)

- ☐ Out of Home Respite Services
- ☐ Adult Day Health Services
- ☐ Home Medical Equipment & Supplemental Adaptive & Assistive Devices

- ☐ Waiver Transportation
- ☐ Chore Services
- ☐ Social Work Counseling
- ☐ Emergency Response Services
- ☐ Home Modification Maintenance and Repair
- ☐ Personal Care Services
- ☐ Homemaker Services
- ☐ Waiver Nursing Services
- ☐ Home Delivered Meals
- ☐ Alternative Meals Service
- ☐ Pest Control
- ☐ Assisted Living Services
- ☐ Home Care Attendant
- ☐ Choices Home Care Attendant
- ☐ Enhanced Community Living Services
- ☐ Nutritional Consultation
- ☐ Independent Living Assistance
- ☐ Community Transportation

Aetna Better Health Inc. (Ohio)	**MedSolutions, Inc.**
_____	_____
By	**By**
_____	_____
Printed Name	**Printed Name**
_____	_____
Title	**Title**
_____	_____
Date	**Date**

PRODUCT PARTICIPATION SCHEDULE

Participation under this Agreement will include the products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Those Medicaid Plans and programs offered by Company within the State of Ohio.
- Those Dual Plans and programs offered by Company within the State of Ohio.

Individual Sites Regulatory Addendum – Exhibit A

PENNSYLVANIA (RISK)

If there is any conflict between the terms of this **Exhibit A** and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this **Exhibit A** will govern and control; provided, however, if there is any conflict between any of the terms of this Agreement, including this **Exhibit A**, and the applicable State Contract (as defined in this Agreement), then the terms of the State Contract will govern and control.

The term "Provider," as it appears throughout this **Exhibit A**, shall refer to Delegated Entity.

I. STATE-REQUIRED TERMS

Capitalized terms used and not otherwise defined in this Pennsylvania HealthChoices Addendum (the "Addendum") shall have the meanings set forth in the Agreement. The parties agree as follows:

3. **Controlling Provisions**. This Addendum shall be attached to, and constitute a part of, the Agreement. Any provisions of this Agreement, including this Addendum, which directly conflict with the terms and provisions of the Prime Contract will be deemed waived, unless such conflict may be resolved through construction or amendment as provided herein. In the event of any inconsistency between the terms of this Addendum and any other part of the Agreement, the terms of this Addendum shall govern and control, and all other terms and provisions of the Agreement not affected by this Addendum shall remain in full force and effect.

4. **Definitions**. The following definitions shall be incorporated into Article 1 of the Agreement. Any conflicting definitions in Article 1 of the Agreement shall be deleted in their entirety and replaced with those set forth below:

   Certified Registered Nurse Practitioner (CRNP). A registered nurse licensed in the Commonwealth of Pennsylvania who is certified by the boards in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in Pennsylvania.

   Department. The Department of Public Welfare (DPW) of the Commonwealth of Pennsylvania.

   Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Items and services which must be made available to persons under the age of twenty-one (21) upon a determination of medical necessity and required by federal law at 42 U.S.C. §1396d(r).

   Emergency Services. Covered inpatient and outpatient services that: (a) are furnished by a Provider that is qualified to furnish such service under Title XIX of the Social Security Act and (b) are needed to evaluate or stabilize an Emergency Medical Condition.

   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, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

   HealthChoices Program. The Pennsylvania 1915(b) waiver program to provide mandatory managed health care to Recipients.

HealthChoices Zone. A multiple-county area in which the HealthChoices Program has been implemented to provide mandatory managed care to Medicaid Recipients in Pennsylvania.

Medical Assistance (MA). The Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, and 62 P.S. and regulations at 55 PA Code Chapters 101 et seq.

Medically Necessary or Medical Necessity. A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

i. The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
ii. The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
iii. The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing. The determination is based on medical information provided by the Member, the Member's family/caretaker and the Primary Care Practitioner, as well as any other providers enrolled in the Pennsylvania MA Program that provide services or supplies to Recipients, programs or agencies that have evaluated the Member. All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

Primary Care Practitioner (PCP). A specific physician, physician group or a CRNP operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of a Recipient.

Prime Contract. The HealthChoices Agreement entered into by Company and the Commonwealth of Pennsylvania, Office of Administration, Contract Policy, Management and Procurement.

Recipient. A person eligible to receive physical and/or behavioral health services under the MA Program of the Commonwealth of Pennsylvania.

Urgent Medical Condition. Any illness, injury or severe condition which under reasonable standards of medical practice, would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or require Emergency Services. The term also includes situations where a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.

5. **Eligibility**. Provider shall not deny services to a Recipient during the eligibility window for MA fee for service payment by the Department to Provider prior to the effective date of Company's initiation of a Member's coverage by Company.

6. **Sanctions**. Provider acknowledges that it may be subject to sanctions (including without limitation those described in Exhibit LL of the Prime Contract) in connection with violations of Federal and state laws and regulations (including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims and prohibition of kickbacks) related to this Agreement, the services to be provided hereunder, and the submission of claims and statements.

7. **Compliance with Applicable Law**. Provider represents and warrants that Provider (i) is certified to participate in the Medicaid program, and (ii) shall comply, and take all steps necessary to cause such

employees, independent contractors and subcontractors to comply, with the Medical Assistance regulations, any enforcement actions directly initiated by Department under its regulations (including termination and restitution actions, among others) and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs, including without limitation the relevant provisions of Medical Assistance Bulletins 1123-91-01 and 99-94-08; Bulletins 1157-95-01, 1165-93-01 and 1165-93-07; 40 P.S. §§ 991.2117(b), 991.2131 and 991.2166; 31 Pa. Code § 154.18; 55 Pa. Code Chapters 1101, 1121, 1123, 1126 - 1130, 1140 - 1145, 1147, 1149, 1150, 1151, 1153, 1163, 1221, 1223, 1225, 1229, 1230, 1241, 1243, 1245, 1249, 3700 and 3800 as amended from time to time; and as otherwise set forth in the Prime Contract.

8. **Encounter Data; Prompt Payment**. For those services for which Provider is compensated on a capitated basis, if any, Provider agrees to cooperate with submission of encounter data within the time frames required by Section VIII of the Prime Contract, "Reporting Requirements" and set forth in the **Encounter Data Submission Schedule** attached hereto, regardless of whether reimbursement for such services is made by Company directly or through capitation. 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 Provider. Provider and Company agree that claims shall be paid consistent with the requirements of 40 P.S. § 991.2166 and 31 Pa. Code § 154.18.

9. **Recipient Restriction Program; Provider IDs**. Provider shall cooperate with Company's and the Department's Recipient Restriction Program, if any. Provider must be enrolled in the Commonwealth's MA Program and possess an active PROMISe™ provider ID.

10. **PIP Disclosures**. Provider shall disclose annually any Physician Incentive Plan (PIP) or risk arrangements it may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no Substantial Financial Risk between Company and the physician or physician group. For purposes of this paragraph, "Substantial Financial Risk" means financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. For purposes of this paragraph, the term "potential payments" means the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. If the cost of referrals exceeds the twenty-five percent (25%) level, the financial arrangement is considered to put the physician or group at Substantial Financial Risk.

11. **Internal Infection Control Plan**. Provider shall develop and implement, in accordance with P.L.154, No. 13 known as the Medical Care Availability and Reduction of Error (Mcare) Act, an internal infection control plan satisfactory to Company that is established for the purpose of improving the health and safety of patients and health care workers and includes effective measures for the detection, control and prevention of Health Care-Associated Infections. For purposes of this paragraph, "Health Care-Associated Infection" shall mean a localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that:
    i) occurs in a patient in a health care setting; and
    ii) was not present or incubating at the time of admission, unless the infection was related to a previous admission to the same setting; and
    iii) if occurring in a hospital setting, meets the criteria for a specific infection site as defined by the Centers for Disease Control and Prevention and its National Healthcare Safety Network.

12. **Moral Objection**. This Agreement will not be construed as requiring Company to provide, reimburse for, or provide coverage of, a counseling or referral service if Provider objects to the provision of such services on moral or religious grounds.

13. **Quality Management/Utilization Management**. Provider will cooperate with the quality management and utilization management program standards outlined in Exhibit M(1) of the Prime Contract, "Quality Management and Utilization Management Program Requirements," and shall participate in and abide by the decisions of Company's quality assurance and utilization review systems.

14. **Medical Records**. All Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable State and Federal laws and regulations, including without limitation Section 1231 of the Health Maintenance Organization Act (40 P. S. § § 1551—1567) and 40 P.S. § 991.2131. Applicable Federal and state authorities, including without limitation the Department, the Department of Health and the Department of Insurance, and their agents shall have access to medical records for assessing the quality of care, for investigating Member grievances or complaints, for enforcement or for other activities related to compliance, provided that such records are only accessible to Department of Health employees or agents with direct responsibilities for such activities.

15. **Interference with Contractual Relations**. Company shall not exclude, sanction, terminate or fail to renew Provider's participation for any of the reasons set forth in the section of the Agreement entitled "Interference With Contractual Relations" in Article 7, or for any of the following reasons: (i) advocating with or on behalf of Member for Medically Necessary and appropriate care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, or discussion of same with Member, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered, nor shall Company prohibit Provider from acting within the lawful scope of practice to do the foregoing; (ii) filing a grievance on behalf of and with the written consent of Member, or helping a Member file a grievance; (iii) providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or nontreatment, nor shall Company prohibit Provider from acting within the lawful scope of practice to do the foregoing; or (iv) maintaining a practice that includes a substantial number of patients with expensive medical conditions.

16. **Termination; Continuation of Services Upon Termination**. Should Provider terminate its agreement with Company, for any reason, Provider shall provide services to Members assigned to the Provider under this Agreement up to the end of the month in which the effective date of the termination falls, and unless Provider is being terminated for cause as described in 40 P.S. § 991.2117(b), Provider must allow a Member to continue an ongoing course of treatment from the Provider for up to sixty (60) days from the date the Member is notified by Company of the termination or pending termination of Provider. Notwithstanding any other provision of this Agreement, if this Agreement terminates as a result of insolvency or other cessation of operations of Company, Provider shall continue to provide benefits to all Members, including Members in an inpatient setting, through the period for which capitation has been paid. A Member is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve (12) months the Member was treated by Provider for a condition that requires follow-up care or additional treatment or the services have been prior authorized. Per Department of Health regulation Title 28, §9.684(d), the transitional period may be extended by Company if the extension is determined to be clinically appropriate. Company shall consult with the Member and Provider in making the determination. Following termination of this Agreement, Provider must also allow a Member who is pregnant to continue to receive care through the completion of the Member's postpartum care. Company hereby informs the Provider that to be eligible for payment for services provided to a Member following termination of this Agreement, Provider must agree to meet the same terms and conditions as other Participating Providers.

17. **Coordination with Behavioral Health Providers**. If applicable, for purposes of coordinating with behavioral health providers, Provider shall:

17.1. Comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including obtaining any required written member consents to disclose confidential medical records.

17.2. Make referrals for social, vocational, education or human services when a need for such service is identified through assessment.

17.3. Provide health records if requested by the behavioral health provider.

17.4. Notify the behavioral health provider of all prescriptions, and when deemed advisable, check with the behavioral health provider before prescribing medication.

17.5. Make certain behavioral health clinicians have complete, up-to-date record of medications.

17.6. Be available to the behavioral health provider on a timely basis for consultations.

17.7. Cooperate with Company to coordinate the provision of behavioral health services with the behavioral health managed care organization managing the purchase and provision of such services in each HealthChoices Zone under an agreement with the Department.

18. **Reporting Suspected Abuse**. If Provider is a hospital or other health care facility, Provider shall ensure that emergency room staff and physicians know and follow the procedures for reporting suspected abuse and neglect, in addition to performing exams for the county.

19. **Signing Authority**. If Provider is a hospital or facility, Provider represents and warrants that it is duly and validly authorized to execute this Agreement on behalf of each Provider-based Physician, and to bind each such Provider-based Physician to perform the obligations set forth herein, as applicable, in accordance with the terms and conditions of this Agreement.

20. **Physician Groups.** If Provider is a physician group, then Provider agrees, on behalf of itself and each Provider physician who has been accepted as a participating Provider physician by Company in accordance with the terms of the Agreement (a "Participating Group Physician"), that (i) all representations, warranties and covenants made by Provider in this Addendum are made by Provider on behalf of itself and each Participating Group Physician, and (ii) Provider will cause each Participating Group Physician to adhere to and perform its obligations under the Agreement in accordance with the applicable terms and conditions of this Addendum.

21. **Internal Infection Control Plan.** If Provider is an ambulatory surgical facility, hospital, or other health care facility, Provider shall develop and implement, in accordance with P.L.154, No. 13 known as the Medical Care Availability and Reduction of Error (Mcare) Act, an internal infection control plan satisfactory to Company that is established for the purpose of improving the health and safety of patients and health care workers and includes effective measures for the detection, control and prevention of Health Care-Associated Infections. For purposes of this paragraph, "Health Care-Associated Infection" shall mean a localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that:

i) occurs in a patient in a health care setting; and
ii) was not present or incubating at the time of admission, unless the infection was related to a previous admission to the same setting; and
iii) if occurring in a hospital setting, meets the criteria for a specific infection site as defined by the Centers for Disease Control and Prevention and its National Healthcare Safety Network.

22. **PCP Responsibilities.** If Provider is a PCP, Provider hereby agrees as follows:

2.12.1 EPSDT Screens. If Provider serves Members under the age of twenty-one (21), Provider shall be responsible for conducting all EPSDT screens for individuals on their panel under the age of twenty-one (21). Should the Provider be unable to conduct the necessary EPSDT screens, the Provider is responsible for arranging to have the necessary EPSDT screens conducted by another network provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Member's Provider medical record. When serving Members under the age of twenty-one (21), Provider shall report encounter data associated with EPSDT screens, using a format approved by the Department, to Company within ninety (90) days from the date of service.

2.12.2 New Members. Provider shall contact new Members identified in the quarterly encounter lists who have not had an encounter during the first six (6) months of enrollment, or who have not complied with the scheduling requirements outlined in the Prime Contract or as otherwise identified by Company or the Department. Provider shall contact Members identified in the quarterly encounter lists as not complying with EPSDT periodicity and immunization schedules for children. Provider must identify to Company any such Members who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of such

notification to the site by Company. Provider shall document the reasons for noncompliance, where possible, and shall document its efforts to bring the Member's care into compliance with the standards. Provider shall contact all Members who have not had an encounter during the previous twelve (12) months or within the time frames set forth in Company Policies and the Prime Contract to arrange appointments.

2.12.3 PCP Services. Provider shall: (a) provide primary and preventive care and act as the Member's advocate, providing, recommending and arranging for care; (b) document all care rendered in a complete and accurate encounter record that meets or exceeds the Department data specifications; (c) maintain continuity of each Member's health care; (d) make referrals for specialty care and other Medically Necessary services, both in and out-of-plan; (e) maintain a current medical record for the Member, including documentation of all services provided to the Member by the Provider, as well as any specialty or referral services; (f) arrange for those behavioral health services for which Company is responsible under the HealthServices Program, as set forth in the Behavioral Health Services Schedule attached hereto.

2.12.4 On-Call Arrangements. Each Provider must have coverage available to Members via a reliable twenty-four (24) hours-a-day, seven (7) days-a-week answering service. A recorded message or answering service which refers Members to emergency rooms is not acceptable.

2.12.5 Eligibility Verification System (EVS). PCP acknowledges that Provider must provide a file at least weekly or more frequently if requested by the Department , via the Department's Provider Reimbursement and Operations Management Information System electronic (PROMISe™), to the Department's EVS contractor, of PCP assignments for all its Members. Provider shall cooperate with Provider as necessary to permit Provider to timely meet this obligation and to ensure that assignment information is consistent with all requirements specified by the Department.

2.12.6 PCP Scheduling Procedures. Each Provider must ensure that:

i. Emergency Medical Condition cases must be immediately seen or referred to an emergency facility.
ii. Urgent Medical Condition cases must be scheduled within twenty-four (24) hours.
iii. Routine appointments must be scheduled within seven (7) Business Days.
iv. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.
v. Member's average office waiting time is no more than twenty (20) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical need. The Member must be informed of scheduling time frames through educational outreach efforts.
vi. Provider knows and follows the procedures for reporting suspected abuse and neglect, in addition to performing exams for the county.

23. Specialist as PCP. If Provider is a specialist serving as a PCP, Provider shall provide or arrange for all primary care, consistent with Company preventive care guidelines, including routine preventive care, and to provide those specialty medical services consistent with the Member's "special need" in accordance with Company's standards and within the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the Provider as a PCP also must have admitting privileges at a hospital in Company's Network. If applicable, Provider will comply with EPSDT screening and encounter data requirements required in the Prime Contract.

24. Modification. Notwithstanding any other provision of this Agreement, any modification, addition, or deletion to the provisions of the section of the Agreement entitled "Member Billing" in Article 4 shall become effective on a date no earlier than fifteen (15) days after the Secretary of Health has received written notice of such proposed changes. In the event any provision of this Agreement violates any laws or is inconsistent with any provision of the Prime Contract, this Agreement shall be construed in a manner

which would satisfy any such laws or Prime Contract, and this Agreement shall be deemed modified as to same. If at any time the Department or any other governmental authority with jurisdiction over the subject matter of this agreement requires modification of the terms and conditions of this Agreement, this Agreement shall be deemed to be automatically amended to conform to such requirements.

25. **Licensure**. 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 issuing one or more Licenses to Company. Provider agrees that all Company obligations to perform, and all rights of Provider, under this Agreement are expressly conditioned upon the receipt of all approvals, consents, licenses, permissions and other authorizations from governmental authorities with jurisdiction over the subject matter of this Agreement or that Company deems to be necessary or desirable in its sole discretion. Failure of Company to obtain any License shall impose no liability on Company under this Agreement.

26. **Prior Agreements**. This Agreement, including this Addendum, will apply only to the Plans described in the Agreement. This Agreement, including this Addendum, will not be construed to nullify, render void, replace or amend any prior written agreements between the Parties (collectively, the "Prior Agreement"); provided, however, that if any provision of a Prior Agreement or any application thereof conflicts with the terms of this Agreement with respect to the Plans, the relevant provisions of this Agreement shall control with respect to the Plans to the extent necessary to resolve such conflict with respect to the Plans, and the remaining portions of the Prior Agreement shall remain in full force and effect.

27. **Subcontractors.** Provider agrees that, to the extent otherwise permitted under this Agreement and the Prime Contract, if Provider delegates or subcontracts any of Provider's duties and obligations hereunder, Provider shall cause any such subcontracted entity to adhere to the applicable terms of the Prime Contract and this Agreement. Any such subcontract or delegation shall be subject to prior written approval by Company, shall include assurances that the persons who sign the subcontract or delegation are authorized to do so, and shall include the following provisions such that the subcontracted entity makes all representations, warranties and covenants made by Provider in this Addendum.

PRODUCT PARTICIPATION SCHEDULE
PENNSYLVANIA - RISK

Participation under this Agreement will include the products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- HealthChoices Physical Health Services
- Children's Health Insurance Program (CHIP)

ENCOUNTER DATA SUBMISSION SCHEDULE
PENNSYLVANIA - RISK

Provider agrees to cooperate with Company for submission of encounter data within the time frames required by Section VIII of the Prime Contract, "Reporting Requirements" and set forth below, regardless of whether reimbursement for such services is made by Company directly or through capitation:

Timing of Data Submittal

I. Provider Claims

Claims must be submitted by Provider to Company within one hundred eighty (180) days after the date of service, or such shorter time period as identified by Company in writing. Claims adjudicated by a third party vendor must be provided to Company by the end of the month following the month of adjudication.

II Encounter Submissions

An encounter record must be submitted and determined acceptable by the Department on or before the last calendar day of the third month after the payment/adjudication calendar month in which Company paid/adjudicated the claim. Encounter records sent to the Department are considered acceptable when they pass all Department edits. Encounter records that deny or suspend due to Department edits are returned to Company and must be corrected. Denied encounter records must be resubmitted as a "new" encounter record if appropriate and within the timeframe referenced above. Suspended encounter records must be corrected and resubmitted as an adjustment within the timeframe referenced above. Corrections and resubmissions must pass all edits before they are accepted by the Department. Failure of subcontractors to submit encounter data timely shall not excuse Company's noncompliance with this requirement or Provider's failure to cooperate with Company's compliance efforts.

III. Encounter File Specifications

Company must adhere to, and Provider shall facilitate Company's adherence to, the file size and format specifications provided by the Department and the encounter file submission schedule provided by the Department.

IV. Subcapitation Data

Subcapitation data must be submitted to the Department in the appropriate encounter format within thirty (30) days of the last calendar day of the month of the subcapitated Provider's payment/adjudication date.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.

By: _____

Printed Name: Phillip S. Clancy

Title: General Counsel

Date: 4.1.14

Aetna Better Health Inc.
(a Pennsylvania corporation)

By: _____

Printed Name: DENISE CROCE

Title: CHIEF EXECUTIVE OFFICER

Date: _____

Effective Date: 3-1-14

Aetna Health Inc.
(a Pennsylvania corporation)

By: _____

Printed Name: DENISE CROCE

Title: CHIEF EXECUTIVE OFFICER

Date: _____

Effective Date: 3-1-14

The following paragraphs are additionally applicable to services rendered for Members of Pennsylvania CHIP Plans. Provider shall render services to Members of Pennsylvania CHIP plan in the same manner as to Members of Pennsylvania Medicaid plans, except as specified herein.

1 The applicable regulator/Government Sponsor for CHIP plans shall be the Pennsylvania Insurance Department, and the State Contract shall be the agreement between Aetna Health Inc., or its successor, and the Pennsylvania Insurance Department.

2 Services rendered for CHIP members shall be conducted in accordance with Title XXI of the federal Social Security Act (authorizing CHIP), and regulations promulgated thereunder, the Children's Health Care Act, Article XXIII of The Insurance Company Law of 1921, 40 P.S. §§ 991.2301 to 991.2362 (establishing CHIP in Pennsylvania), Article XXI of the Insurance Company Law of 1921, added by Act 68 of 1998 (governing quality health care accountability and protection), and 40 P.S. §§ 991.2101, et seq., and including its implementing regulations as promulgated by the Department of Health and the Department. Payments made under the CHIP program constitute receipt of federal funds.

3 For services to CHIP Members, Provider shall retain records for a minimum of five (5) years from the expiration date of the State Contract or as otherwise required by law, except that if an audit is in progress or audit findings are yet unresolved, records shall be kept until all tasks are completed.

4 Non-discrimination

4.1 In the hiring of any employee(s) for the manufacture of supplies, performance of work, or any other activity required under the Agreement, Provider shall not, by reason of gender, race, creed, or color, discriminate against any citizen of the Commonwealth of Pennsylvania who is qualified and available to perform the work to which the employment relates.

4.2 Provider shall not in any manner discriminate against or intimidate any employee involved in the manufacture of supplies, the performance of work, or any other activity required under this Agreement on account of gender, race, creed, or color.

4.3 Provider shall establish and maintain a written sexual harassment policy and shall inform employees of the policy. The policy must contain a notice that sexual harassment will not be tolerated and employees who practice it will be disciplined.

4.4 Provider shall not discriminate by reason of gender, race, creed, or color against any subcontractor or supplier who is qualified to perform the work to which this Agreement relates.

4.5 Provider shall, within the time periods requested by the Commonwealth, furnish all necessary employment documents and records and permit access to their books, records, and accounts by the Department and the Bureau of Small Business Opportunities (BSBO), for purpose of ascertaining compliance with provisions of this Nondiscrimination/Sexual Harassment Clause.

5 **Lobbying Disclosures.** Provider shall execute and return to Company a "Certification for Contracts, Grants, Loans, and Cooperative Agreements" in a form acceptable to Company.

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

Aetna Better Health – Pennsylvania
2000 Market St. #800
Philadelphia, PA 19103
Attention: CEO

Individual Sites Regulatory Addendum – Exhibit A

TEXAS

If there is any conflict between the terms of this **Exhibit A** and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this **Exhibit A** will govern and control; provided, however, if there is any conflict between any of the terms of this Agreement, including this **Exhibit A**, and the applicable State Contract (as defined in this Agreement), then the terms of the State Contract will govern and control.

The term "Provider," as it appears throughout this **Exhibit A**, shall refer to MedSolutions.

I. STATE-REQUIRED TERMS

Capitalized terms used and not otherwise defined in this Addendum (the "Addendum") shall have the meanings set forth in the Agreement. The parties agree as follows:

28. **Controlling Provisions**. This Addendum shall be attached to, and constitute a part of, the Agreement. Any provisions of this Agreement, including this Addendum, which directly conflict with the terms and provisions of the Prime Contract will be deemed waived, unless such conflict may be resolved through construction or amendment as provided herein. In the event of any inconsistency between the terms of this Addendum and any other part of the Agreement, the terms of this Addendum shall govern and control, and all other terms and provisions of the Agreement not affected by this Addendum shall remain in full force and effect.

29. **Definitions**. The following definitions shall be incorporated into Article 1 of the Agreement. Any conflicting definitions in Article 1 of the Agreement shall be deleted in their entirety and replaced with those set forth below:

Clean Claim. 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) 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-92 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.

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 by Company pursuant to contracts with federal and/or state government agencies to serve beneficiaries eligible for Medicaid,

Medically Necessary or Medical Necessity. Health care services that a physician, 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 recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Post-stabilization Care Services. Defined in Exhibit A of this Agreement 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.

Provider: For purposes of this Addendum, "Provider" shall mean the health care provider executing this Agreement, as identified on the first page of the Agreement.

30. **Compliance with Applicable Law**. Provider represents and warrants that Provider (i) is certified to participate in the Medicaid and Medicare program, and (ii) shall comply, and take all steps necessary to cause such employees, independent contractors and subcontractors to comply, with all applicable laws, rules and regulations and perform all requirements applicable to Government Programs, including without limitation applicable Government Sponsored directives and the relevant provisions as amended from time to time; and as otherwise required by Government Sponsored directives.

31. **Signing Authority**. If Provider is a hospital or facility, Provider represents and warrants that it is duly and validly authorized to execute this Agreement on behalf of each Provider-based Physician, and to bind each such Provider-based Physician to perform the obligations set forth herein, as applicable, in accordance with the terms and conditions of this Agreement.

32. **Physician Groups**. If Provider is a physician group, then Provider agrees, on behalf of itself and each Provider physician who has been accepted as a participating Provider physician by Company in accordance with the terms of the Agreement (a "Participating Group Physician"), that (i) all representations, warranties and covenants made by Provider in this Addendum are made by Provider on behalf of itself and each Participating Group Physician, and (ii) Provider will cause each Participating Group Physician to adhere to and perform its obligations under the Agreement in accordance with the applicable terms and conditions of this Addendum.

33. **Modification**. In the event any provision of this Agreement violates any laws or is inconsistent with any provision of the Prime Contract, this Agreement shall be construed in a manner which would satisfy any such laws or Prime Contract, and this Agreement shall be deemed modified as to same. If at any time the Government Sponsor or any other governmental authority with jurisdiction over the subject matter of this agreement requires modification of the terms and conditions of this Agreement, this Agreement shall be deemed to be automatically amended to conform to such requirements.

34. **Licensure**. 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.

35. **Prior Agreements**. This Agreement, including this Addendum, will apply only to the health plans described in the Agreement. This Agreement, including this Addendum, will not be construed to nullify, render void, replace or amend any prior written agreements between the Parties (collectively, the "Prior Agreement").

36. **Subcontractors**. Provider agrees that, to the extent otherwise permitted under this Agreement and the Prime Contract, if Provider delegates or subcontracts any of Provider's duties and obligations hereunder, Provider shall cause any such subcontracted entity to adhere to the applicable terms of the Prime Contract and this Agreement. Any such subcontract or delegation shall be subject to prior written approval by Company, shall include assurances that the persons who sign the subcontract or delegation are authorized to do so, and shall include the following provisions such that the subcontracted entity makes all representations, warranties and covenants made by Provider in this Addendum.

II. PROGRAM PARTICIPATION REQUIREMENTS

Provider agrees to participate in the Plans and other health benefit programs listed herein:

Those CHIP and Medicaid Plans and programs offered by Company within the State of Texas.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.

By:_____

Printed Name:_____

Title:_____

Date:_____

Aetna Health Inc.
(a Texas corporation)

By:_____

Printed Name: _____

Title:_____

Date:_____

Effective Date: _____

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

Aetna Better Health – Texas
2777 Stemmons Freeway, Suite 300
Dallas, Texas 75207
Attention: CEO

Regulatory Compliance Addendum – Exhibit A

VIRGINIA

If there is any conflict between the terms of this **Regulatory Compliance Addendum - Exhibit A** and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this **Exhibit A** will govern and control; provided, however, if there is any conflict between any of the terms of this Agreement, including this **Exhibit A**, and the State Contract, then the terms of the State Contract will govern and control.

1.0 Definitions. For purposes of this **Exhibit A**, the term "Provider" shall mean the health care provider executing this Agreement, as identified on the first page of the Agreement. All capitalized terms in this **Exhibit A** shall have the meaning set forth in the Agreement unless otherwise defined herein, in which case the definitions contained in this **Exhibit A** shall control.

1.1 **Applicable Law**. All federal or state laws, rules, regulations, and administrative agency directives applicable to the Medicaid program and to Medicaid managed care plans, as these may be amended from time to time, including statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kickbacks. Applicable Laws include the Centers for Medicare and Medicaid Services ("CMS") and the Virginia Department of Medical Assistance Services' ("DMAS") instructions, policy letters or guidelines that regulate the actions of Provider or Company, requirements of the State Plan, as applicable, and requirements of the State Contract. The "State Plan" is the State Plan for Medical Assistance, submitted to CMS by DMAS describing the nature and scope of the Virginia Medicaid program. DMAS has the authority to administer the State Plan under Code of Virginia § 32.1-325. The words "applicable law," as they appear in the Agreement, shall have the same meaning as given to "Applicable Law" herein.

1.2 **Clean Claim**. A claim (i) that has no material defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim; or (ii) such other definition as may be required by Applicable Law.

1.3 **Medically Necessary or Medical Necessity**. Appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose.

2.0 Virginia Medicaid Managed Care Required Provisions. The following provisions are required in accordance with
the State Contract. Provider agrees to abide by, and to **cause its employees, agents, independent contractors and subcontractors to abide by,** all applicable provisions of the State Contract. Such compliance with the State Contract specifically includes but is not limited to the following requirements:

2.1 **Provider Cooperation with Company Programs**. Provider agrees to participate in and contribute required data to Company's quality improvement and other assurance programs as required by the State Contract. Provider also agrees to cooperate with any review of Company or the Plan conducted by the National Committee for Quality Assurance ("NCQA") or a federal or state agency with authority over Company or the Plan, as applicable.

2.2 **Emergency / Urgent Care**. Provider agrees to abide by the terms of the State Contract for the timely provision of Emergency Services and urgent care. Where applicable, Provider agrees to follow those procedures for handling urgent cases and Emergency Services cases stipulated in any required hospital/emergency department Memoranda of Understanding signed by Company in accordance with the State Contract. Provider agrees to clearly notify Members of provisions for urgent care or Emergency Services when Provider is not available after hours.

2.3 **Utilization Data**. Provider agrees to submit to Company utilization data in the format specified by

Company.

2.4 **Non-discrimination**. In addition to any other non-discrimination requirements within this Agreement, Provider agrees to comply with all non-discrimination requirements of the State Contract.

2.5 **Record Retention & Access**. Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in the State Contract.

2.6 **Access to Facilities, Records**. Provider agrees to provide representatives of Company and duly authorized agents or representatives of DMAS, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Control Unit access to its premises and its contract and/or medical records in accordance with the State Contract. Provider must forward to Company medical records within ten (10) working days of Company's request.

2.7 **Confidentiality of Medical Records**. Provider agrees to preserve the full confidentiality of medical records in accordance with the State Contract. Provider agrees to enter into a business associate agreement with Company that is compliant with all applicable provisions of HIPAA, as required by the State Contract or other provision of Applicable Law. For all referrals that require sharing a Member's medical information, Provider agrees to obtain all necessary written and informed consent from any Member prior to release of a Member's medical information.

2.8 **Member Access to Medical Records**. Provider agrees to the requirements for maintenance and transfer of medical records stipulated in the State Contract. Provider agrees to make medical records available to Members and their authorized representatives within ten (10) working days of the record request.

2.9 **Disclosure for Credentialing**. Provider agrees to disclose the required information, at the time of application, credentialing, and/or re-credentialing, and/or upon request, in accordance with 42 C.F.R. Part 455, Subpart B, as related to ownership and control, business transactions, and criminal convictions for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. Part 455, Subpart B, Sections 100 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs.

2.10 **Additional Member Privacy Requirement**. Provider agrees to ensure confidentiality of family planning services in accordance with the State Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

2.11 **No Barriers to Care**. Provider agrees not to create barriers to access to care by imposing requirements on Members that are inconsistent with the provision of Medically Necessary and Covered Services.

2.12 **Explaining Plan Requirements**. Provider agrees to clearly specify referral approval requirements to its providers, employees and contractors, and within any subcontracts. Additionally, Provider agrees to hold Members harmless for charges for any Covered Service in accordance with the State Contract. This includes those circumstances where Provider, its employees, or its contractors fail to obtain necessary referrals or preauthorization, or fail to perform other required administrative functions.

2.13 **Restriction on Billing Members**. Provider agrees not to bill a Member for Covered Services provided during the Member's period of Plan enrollment, except as permitted by the State Contract. This provision shall continue to be in effect even if Company becomes insolvent. However, if a Member agrees in advance of receiving the service and in writing to pay for a non-Covered Service, as more particularly set forth in the section of the Agreement entitled "Permitted Billing of Members," then Provider may bill a Member directly for such service.

2.14 **Prompt Provision of Covered Services**. Provider shall promptly provide or arrange for the provision of all Covered Services required under this Agreement. This provision shall continue to be in effect for periods for which Provider has been paid even if Provider becomes insolvent until such time as the Members are

withdrawn from assignment to Provider.

2.15 **Provider Panel**. Providers serving as a Primary Care Physician ("PCP") pursuant to this Agreement agree to act as a PCP for Members, the number of which will not exceed the panel size limits set forth in the applicable State Contract.

2.16 **Post Termination Services of PCPs**. Except in the case of death or illness, in accordance with Virginia Code § 38.2-5805(C)(1), Provider agrees to notify Company at least sixty (60) days in advance of disenrollment from participation in the Plan, and agrees to continue care for his or her assigned Members for up to thirty (30) days after such disenrollment, until another PCP is chosen or assigned, or for such longer period as may otherwise be required by the terms of this Agreement.

2.17 **State Appropriations**. Notwithstanding any other provision to the contrary, Provider acknowledges that the obligations of Company and DMAS for purposes of this Agreement shall be limited to annual appropriations made by the Virginia General Assembly. If the Virginia General Assembly and/or Governor implement a rate decrease for Medicaid services or providers and these rate adjustments are incorporated into the State Contract payment rates during the Term, Company may, in its sole discretion, decrease compensation to Provider under this Agreement, beginning on the effective date of the state rate adjustment, provided that the amount of such decrease shall be consistent with the State Contract.

2.18 **Validity of Terms**. No terms of this Agreement are valid which terminate legal liability of Company in the State Contract.

2.19 **Compliance with Quality of Care Standards**. Provider shall comply and cause its employees, agents, independent contractors and subcontractors to comply with all applicable federal and state mandates, community standards for quality of care, and standards developed pursuant to the DMAS managed care quality program.

2.20 **Provider Representation**. Provider represents, warrants, and covenants, as applicable, that Provider is not an "Ineligible Provider or Administrative Entity" as such term is used and described in the State Contract.

3.0 Commonwealth of Virginia Regulatory Requirements. The following provisions are required by Applicable Law.

3.1 **Hold Harmless**. In accordance with Virginia Code § 38.2-5805(C)(10), Provider acknowledges and agrees that, for purposes of the section of the Agreement entitled "Holding Members Harmless," the term Company includes Company's third-party subcontractors.

3.2 **Interest on Late Paid Claims**. Company shall pay interest on late paid claims as required by Virginia Code § 38.2-4306.1 and the State Contract.

4.0 Miscellaneous. The following provisions are hereby incorporated into the Agreement.

4.1 **Effectiveness of this Agreement**. This Agreement shall have no force or effect unless and until Company executes an agreement with DMAS to offer a Plan in Provider's service area.

4.2 **Subcontractor**. Notwithstanding anything to the contrary within the section of the Agreement entitled "Successors: Assignment," Company may subcontract with a third party for the performance of any of Company's rights or duties under this Agreement, as permitted by the State Contract. Upon notice of execution of such subcontracts, Provider agrees to recognize and cooperate with such third party, its employees, agents and subcontractors in all respects, as if such third parties were Company, its employees and agents.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.

By:_____

Printed Name:_____

Title:_____

Date:_____

Carillon Clinic Medicare Resources, LLC dba MajestaCare

By:_____

Printed Name: _____

Title:_____

Date:_____

Effective Date: _____

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

CEO
Carillon Clinic Medicare Resources, LLC
dba MajestaCare
213 S Jefferson
Suite 101
Roanoke, VA 24011

PRODUCT PARTICIPATION SCHEDULE

Participation under this Agreement will include the products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Those Medicaid Plans and programs offered by Company within the State of Virginia.

Exhibit B

Company Affiliates
including all products listed in Exhibit A

Affiliate Name	Address	City	State	Zip
Mercy Care Plans*	4350 E. Cotton Center Blvd.	Phoenix	Arizona	85040
Delaware Physicians Care, Incorporated	252 Chapman Road	Newark	Delaware	19702
Aetna Better Health – Illinois	1 Wacker Drive	Chicago	Illinois	60606
Aetna Better Health – Ohio	Not yet determined	Not yet determined	Ohio	Not yet determined
Aetna Better Health Inc. (Pennsylvania)	2000 Market St., #800	Philadelphia	Pennsylvania	19103
Aetna Health Inc. (Pennsylvania) d/b/a Aetna Better Health Kids	2000 Market St., #800	Philadelphia	Pennsylvania	19103
Carillon Clinic Medicine Resources, LLC dba MajestaCare*	213 S Jefferson Suite 101	Roanoke	Virginia	24011
Maryland Physicians Care*	509 Progress Drive Suite 117	Linthicum	Maryland	21090
Aetna Better Health – New York	55 W 125th Street Suite 1300	New York	New York	10027
Aetna Better Health – New Jersey	Not yet determined	Not yet Determined	New Jersey	Not yet determined
Aetna Better Health – Texas	2777 Stemmons Freeway Suite 300	Dallas	Texas	75207

***Non-Affiliated Plans administered by Company with access to this Agreement.**

Exhibit C

Intentionally left blank

Exhibit D

Addendum for Medicare-Medicaid Dual Eligible Members

This Addendum for Medicare-Medicaid Dual Eligible Members ("Addendum") shall govern the provision of Covered Services to Members dually eligible for both Medicare and Medicaid. For purposes of this Addendum, the term "Provider" shall mean the Provider executing this Agreement, as identified on the first page of the Agreement. If there is any conflict between the terms of this Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this Addendum will govern and control (except as stated in paragraph 3); provided, however, if there is any conflict between any of the terms of this Agreement, including this Addendum, and the State Contract (as defined in the Agreement), then the terms of the State Contract will govern and control. To the extent possible under applicable law, the terms below shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the remainder of the Agreement.

1. Provider agrees to comply with all applicable state and federal laws, rules, regulations, and the Centers for Medicare and Medicaid Services (CMS) instructions, as well as Company requirements designed to ensure Company's compliance with such laws, rules, regulations, including, without limitation, laws, rules and regulations relating to the protection of Member privacy and confidentiality and the accuracy of Member health records, which Provider shall safeguard and ensure. Provider agrees to abide by state and federal privacy and security requirements, including the confidentiality and security provisions stated in 42 C.F.R. § 422.118. Provider agrees that all services and other activities performed by Provider under the Agreement will be consistent and comply with Company's obligations under its contract(s) with CMS and other Government Sponsors to offer Medicare-Medicaid Dual Eligible Plans. Upon request, Provider shall immediately provide to Company any information required by Company to meet its reporting obligations to CMS and other Government Sponsors, including, where applicable, physician incentive plan information. Provider acknowledges and agrees to allow CMS, other Government Sponsors and Company to monitor Provider's performance under this Agreement on an ongoing basis, in accordance with applicable laws, rules and regulations.

2. Provider acknowledges and agrees that all provisions of this Addendum and of the Agreement shall apply equally to any employees, independent contractors and subcontractors of Provider who provide or may provide Covered Services to Members, and Provider represents and warrants that Provider shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply with this Addendum and the Agreement and all applicable laws and regulations, and perform all requirements applicable to Medicare and Medicaid programs.

3. This paragraph 3 applies only if payment timeframes are not specified elsewhere in the Agreement: Company agrees to pay Provider for Covered Services rendered to Members within forty-five (45) calendar days of actual receipt by Company of a Clean Claim. Payments for non-capitated Covered Services rendered to Members are subject to any and all valid and applicable laws related to claims payment. With respect to Medicare and Medicaid Members, Provider acknowledges that compensation under the Agreement for such Members constitutes receipt of federal funds. Provider shall pay on a timely basis all employees, independent contractors and subcontractors who render Covered Services to Members for which Provider is financially responsible pursuant to the Agreement.

4. Provider acknowledges and agrees that 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 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.

5. As stated in the Agreement, Provider agrees to cooperate with and participate in internal and external review procedures necessary to process Members' appeals and grievances.

6. Provider agrees to provide Company and federal, state and local governmental authorities having jurisdiction, or their designees (including the U.S. Department of Health and Human Services (HHS), the Comptroller General or their designees), upon request, access to all books, contracts, computer or other electronic systems, (including, but not limited to, medical and financial records) and information relating to the Agreement and to those Services rendered by Provider and its employees, independent contractors and subcontractors ("Information and Records"), and that this right of inspection, evaluation and audit exists through ten (10) years from the final date of any contract period or the date of completion of any audit, whichever is later. Provider also agrees to maintain Information and Records for ten (10) years from the final date of any contract period or the date of completion of any audit, whichever is later. This Section shall survive the termination of the Agreement, regardless of the cause of the termination.

7. Provider agrees to comply with the following, as applicable and as amended from time to time: Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, HIPAA administrative simplification rules at 45 C.F.R. parts 160, 162, and 164, the Americans with Disabilities Act, 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 other laws applicable to recipients of Federal funds.

8. In no event, including without limitation, non-payment by Company, insolvency of Company or breach of the Agreement or this Addendum, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or persons (other than the Company) acting on a Member's behalf for services covered by the Agreement. This provision shall not prohibit collection of deductibles, coinsurance or copayments from Members in accordance with the terms of the Member's agreement with Company, and, for Medicaid members, only if permitted by applicable law. Provider further agrees that: (a) this provision shall survive termination of the Agreement and this Addendum regardless of the cause giving rise to termination and shall be construed for the benefit of Members, and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Member or persons acting on a Member's behalf. No modification of this provision shall be effective without the prior written approval of the appropriate state and/or federal regulatory entities.

9. In the event of Company's insolvency or other cessation of operations, Provider shall continue to provide Covered Services to (i) Members through the period for which premium has been paid to Company, and (ii) those Members who are confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate discharge.

10. Provider acknowledges that Company may only delegate activities or functions to Provider in a manner consistent with Medicare laws, rules and regulations. Provider acknowledges and agrees that if any of Company's activities or responsibilities under Company's contract with CMS and Government Sponsor to offer Plans is delegated by Company to Provider, such activity or responsibility may be revoked if CMS or Company determines that Provider has not performed satisfactorily. To the extent Company has delegated activities or functions to Provider pursuant to a separate delegation agreement, such agreement shall specify the duties and reporting obligations of Provider, and the terms of this Addendum shall be incorporated therein, if not already expressly stated therein.

    If Company consents, Provider may sub-delegate a portion of its responsibilities under the Agreement to a third party approved by Company ("Sub-Delegate"); provided, however, Provider agrees that it is responsible for ensuring that any Sub-Delegate adheres to the requirements of this Addendum and the Agreement; provided, further, Provider and any Sub-Delegated entity shall enter into an agreement setting forth the respective responsibilities of the parties, which shall comply with applicable accreditation standards. Such sub-delegation shall not relieve Provider of its obligations under this Addendum or the

Agreement. Provider acknowledges and agrees that all provisions of this Agreement shall apply equally to any Sub-Delegate that provides any services under this Agreement, and Provider represents and warrants that it shall take all steps necessary to cause such Sub-Delegates to comply with this Agreement and all applicable laws, rules and regulations

Provider further acknowledges and agrees that any contract that Provider enters into with a Sub-Delegate relating to any services that Provider is responsible to perform under this Agreement for Medicare-Medicaid Dual Eligible Plans ("Delegated Subcontract"): (i) must contain provisions that require the Sub-Delegate to comply with any and all obligations and duties imposed on Provider in this Agreement (ii) must contain all provisions required under Medicare laws, rules and regulations, and (iii) is subject to all of Company's obligations under Medicare laws, rules and regulations related to such Delegated Subcontract.

11. The credentials of medical professionals affiliated with Provider will be reviewed by Company in accordance with Company's polices as stated in the Agreement. If such credentialing process has been delegated to Provider as a part of this Agreement or in a separate Agreement, the credentialing process will be reviewed and approved by Company and Company shall audit the credentialing process on an ongoing basis. If Company has delegated a selection of providers, contractors, or subcontractors, Company shall retain the right to approve, suspend or terminate any arrangement with a provider, contractor or subcontractor.

12. For purposes of this Section 12, "risk adjustment data" shall have the meaning set forth in 42 C.F.R. Section 422.310(a), as may be amended from time to time. Company may be required to obtain risk adjustment data from Provider for Members, and Provider agrees to provide complete and accurate risk adjustment data to Company for Members that conforms to all standards and requirements set forth in applicable laws, rules and regulations and/or CMS instructions that apply to risk adjustment data. Provider certifies, based on best knowledge, information and belief, that any risk adjustment data that Provider submits to Company for Members is accurate, complete and truthful. Provider agrees to immediately notify Company if any risk adjustment data that was submitted to Company for Members is erroneous, and follow procedures established by Company to correct erroneous risk adjustment data to ensure Company's compliance with applicable laws, rules and regulations and CMS instructions.

    Provider further agrees to maintain accurate, legible and complete medical record documentation for all risk adjustment data submitted to Company for Members in a format that meets all standards and requirements set forth in applicable laws, rules, regulations and/or CMS instructions, and allows any federal governmental authorities with jurisdiction or their designees ("Government Officials") to: (1) confirm that the appropriate diagnoses codes and level of specificity are documented ; (2) verify the date of service is documented and within the risk adjustment data collection period; and (3) confirm that the appropriate Provider's signature and credentials are present ("Medical Records").

    Provider 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 risk adjustment data ("Audit Data"). Provider 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 CMS conducts a review that includes the validation of risk adjustment data submitted by Provider, Company will submit to Provider a copy of the CMS written notice of such review, along with a written request from Company for Audit Data.

13. Provider agrees to immediately notify Company in the event that Provider, any participating provider, or any of Provider's employees, contractors, subcontractors, agents or any other individual or entities that assist or are involved in Provider's performance of services for under the Agreement ("Provider Related Parties") are or become disbarred, excluded, suspended, or otherwise determined to be ineligible to participate in a federal health care program. At a minimum, Provider agrees to review the Department of Health and Human Services Office of Inspector General ("OIG") and General Service Administrative ("GSA") exclusion lists ("Exclusion Lists") on an annual basis (unless more frequently required under applicable laws, rules and/or regulations) to ensure that Provider Related Parties are not included on the Exclusion Lists. Provider shall not employ or contract with, with or without compensation, any individual

or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in a federal health care program. Provider agrees that if a Provider Related Party appears on an Exclusion List and/or is excluded from participation in any federal health care program, Provider will immediately remove the Provider Related Party from any work related directly or indirectly to services under this agreement and take all corrective actions required under applicable laws, rules or regulations. Company may immediately terminate or suspend the Agreement upon notice to Provider, at Company's sole discretion at any time if Provider is debarred, sanctioned or suspended from participation in any federal health care program, including, but not limited to, the Medicare or Medicaid programs.

14. 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, contractor, 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 Addendum, 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.

15. Provider 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.

8.3 Regulatory Fines. The parties also acknowledge that the services delegated under this Agreement are subject to regulation by applicable federal and state laws and regulations. If Delegated Entity does not or is not able to fulfill any or all of its obligations under this Agreement and Company is subject to any fines or fees from a regulatory agency as a result thereof, Delegated Entity agrees to pay to Company the amount of such fines and any penalties incurred, including any applicable interest. Company shall have sole discretion to pay such fees, fines or penalties or to settle or compromise with such regulatory agencies.

FIRST AMENDMENT TO THE NATIONAL RADIOLOGY MANAGEMENT SERVICES AGREEMENT BETWEEN AETNA MEDICAID ADMINISTRATORS LLC AND MEDSOLUTIONS, INC.

This First Amendment (the "Amendment") to the National Radiology Management Services Agreement (hereinafter the "Agreement") is made as of April 1, 2014 (the "Effective Date"), by and between Aetna Medicaid Administrators LLC (formerly known as Schaller Anderson, LLC), on behalf of itself and its Affiliates (hereinafter "Company"); and MedSolutions, Inc., a Tennessee corporation with its principal place of business in Franklin, TN ("Delegated Entity").

WHEREAS, the parties have entered into the Agreement for the provision of Utilization Management services ("UM Program") in accordance with the terms of the Agreement; and

WHEREAS, the parties wish to amend the Agreement to add a Musculoskeletal Pain Management UM Program to the Description of Delegated Entity Services and to add this service to the Compensation Schedule between the parties for the provision thereof.

NOW, THEREFORE, in consideration of the mutual promises and undertakings contained herein, the parties agree to be legally bound as follows:

1. Exhibit I shall be amended by adding the attached Exhibit 1A Musculoskeletal Pain Management Services Addendum and Exhibit 1 B Musculoskeletal Pain Management Services and Compensation Schedule to the Agreement.

2. The parties agree that all references, where applicable, to the Radiology Management Program shall apply to the Musculoskeletal Pain Management Program, unless the context otherwise requires..

3. The Musculoskeletal Pain Management program shall not become effective for any Affiliate until such time as Company notifies Delegated Entity of the effective date for Affiliate. Such notice shall be in writing via letter or acceptable electronic format.

All other terms and conditions not otherwise amended herein shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

MEDSOLUTIONS, INC.

By: _____ (Signature)

Printed Name: Alan Reinitzer

Title: SVP- Financial Ops

Date: 3.27.14

Tax I.D. Number: 62-1615395

AETNA MEDICAID ADMINISTRATORS LLC

By: _____ (Signature)

Printed Name: Robert M. Kessler

Title: Secretary

Date: March 31, 2014

EXHIBIT 1 A
Musculoskeletal Pain Management Services Addendum

This Exhibit shall be governed by and construed in accordance with the terms and conditions of the Radiology Management Services Agreement (the "Agreement") entered into by and between Aetna Medicaid Administrators LLC and Delegated Entity. The Parties agree that any changes or revisions in the standards described in this Exhibit or any new standards developed by Company in accordance with the Agreement shall be considered an amendment for the purposes of this Agreement. Musculoskeletal Services are available at the discretion of any Company Affiliate, which may, but is not required to, implement such services in its respective market.

1. DEFINITIONS

1.1 **"Completed Medical Necessity Determination"** shall mean the Medical Necessity Determination, applicable Reason Code, and all supporting documentation in making the Medical Necessity Determination.

1.2 **"Medical Director"** shall mean the person described in Section 3.4.2 of this Addendum.

1.3 **"Medical Necessity Determination"** shall mean the Determination made by the Peer Reviewer (and explanation of such Determination) as to the Medical Necessity of Covered Services performed or to be performed by Participating Provider to or for a Member.

1.4 **"Medical Necessity Determination Review"** shall mean the process by which a Peer Reviewer applies the Criteria in the Medical Policy to make a Medical Necessity Determination as to whether Covered Services are Medically Necessary.

1.5 **"Medical Necessity Review Request"** shall mean the formal request made by Company for Delegated Entity to perform a Medical Necessity Determination Review on Covered Services to be received by a Member, such as a specific request for pre-payment audit or retrospective review of an unpaid claim/ claim file provided to Delegated Entity by Company, or a Prior Approval Request received by Delegated Entity from a Participating Provider on Covered Services to be received by a Member.

1.6 **"Peer Reviewer"** shall mean a licensed healthcare provider of the same or similar specialty of the requesting physician who makes Medical Necessity Determinations pursuant to this Addendum.

1.7 **"Prior Approval Request"** shall mean the request to either Delegated Entity or Company from a Participating Provider or a Member for a Medical Necessity Determination on a pre-service basis.

1.8 **"Procedure Code"** shall mean the code reported by Providers for Covered Services and submitted on a claim or request for Medical Necessity Determination Review, including, without limitation, a Prior Approval Request.

1.9 **"Provider Inquiries"** shall mean the process Company makes available to Providers in which Prior Approval Requests that have been denied or partially denied can be reconsidered. It is not part of the Company provider appeal process.

1.10 **"Reason Code"** shall mean the code associated with the reason for the Medical Necessity Determination made by a Peer Reviewer with respect to each Medical Necessity Determination Review.

1.11 **" UM Services"** shall mean the Services contracted to Delegated Entity to conduct a Medical Necessity Determination Review that results in a Medical Necessity Determination and other Services described in this Addendum.

1.12 **"Utilization Management" or "UM"** shall mean the comprehensive utilization management program, including, without limitation, receiving and validating clinical data related to proposed or previously rendered Covered Services to Member, performance of Medical Necessity Determination Reviews, and the process of making Medical Necessity Determination, communicating the clinical rationale and medical evidence supporting the Medical Necessity Determinations to Providers and Members, Peer to Peer conversations, analyzing and reporting data related to Medical Necessity Determinations and integrating program outcomes and current medical evidence to improve the quality of healthcare services delivered to Members.

All capitalized terms not otherwise defined herein shall have the meanings given to them in the Agreement.

2. **Deliverables.** Delegated Entity shall provide to Company the UM Services that include the following Deliverables as more fully described in this Addendum.

2.2 **Documentation.** Delegated Entity shall provide to Company all Documentation necessary for Company to understand and evaluate the Services, including, without limitation, Delegated Entity's UM program description and the UM policies and procedures.

2.3 **Training.** Delegated Entity shall provide training to Company employees, agents, consultants, and Providers for such persons to have access to, and operate effectively under, the System with respect to the Services.

2.4 **Call Center Services.** Delegated Entity shall maintain and operate a call center in which Company employees or Providers may contact knowledgeable Delegated Entity personnel to receive answers concerning the Services, including, without limitation, Determinations with respect to Medical Necessity Determinations and the reasons therefore.

2.5 **Scripts.** Delegated Entity shall devise and implement communication material ("Scripts") to be utilized in accordance with Section 6 of this Addendum.

2.6 **Reports.** Delegated Entity shall create and provide to Company reports in form and content acceptable to Company for Company to utilize and evaluate the UM Services delegated to Delegated Entity and to determine the efficacy of the Services in accordance with Section 8 of this Addendum.

2.7 Criteria. Delegated Entity shall devise and furnish to Company the Criteria, and Delegated Entity shall utilize the Criteria as set forth in the Medical Policy and all National and Local Coverage Determinations issued by CMS in making Medical Necessity Determinations for Medicare Members.

2.8 Implementation. Delegated Entity shall provide a comprehensive implementation task **list at least 90 (ninety) days** prior to any Affiliate "go live" date, and will conduct weekly calls with the respective Affiliate prior to, and for at least 60 sixty days post "go live". Company and Delegated Entity may agree to a different timeline if appropriate.

3. Services

3.1 Medical Necessity Reviews. The following process will be followed for pre-service, [concurrent service] and suspended claim reviews as well as reviews based on Provider Inquiries.

3.1.1 When a Provider or Company submits a Prior Approval Request or Provider Inquiry form to Delegated Entity, the form shall include all medical records on the Member submitted by the requesting Provider for purposes of Delegated Entity completing the Medical Necessity Review. Chiropractors will not be utilized.

3.1.2 For Musculoskeletal Services, Delegated Entity shall use a similar or same specialty Peer Reviewer to complete the Medical Necessity Review that results in a Medical Necessity Determination to deny or partially deny the Prior Approval Request or Provider Inquiry, as applicable. The Peer Reviewer performing the Medical Necessity Review will document the applicable Reason Code and any other information relevant to the Medical Necessity Determination, including the applicable Criteria in the Medical Policy, and, Delegated Entity shall submit to Company such information as part of the Completed Medical Necessity Review.

3.1.3 If the Medical Necessity Determination cannot be made without communication of the Prior Approval Request or Provider Inquiry with the Provider or if the Medical Necessity Determination or Provider Inquiry will result in a denial or partial denial of Covered Services, Delegated Entity will first seek to communicate with the Provider telephonically to discuss the Medical Necessity Review. The Peer Reviewer will collect all additional information from the Provider, including any additional documentation supporting the Prior Approval Request or Provider Inquiry, as applicable, review such information for purposes of the Medical Necessity Determination, and include such documentation in the Completed Medical Necessity Medical Review. In the event the Provider fails to provide all the information necessary for Delegated Entity to process a Prior Approval Request or Provider Inquiry within the time frame specified in the applicable Process Documents and Performance Specifications, Delegated Entity shall make the Medical Necessity Determination with all available information and provide Company with the Completed Medical Necessity Review.

3.1.4. Delegated Entity will communicate with the Provider and Member with regard to the Medical Necessity Determination in a form and manner acceptable to Company within the legally required format and time frame.

3.1.5 If agreed to by the parties, Delegated Entity will work with Company to develop patient education materials that will be sent to each member who has been approved for a pain management procedure. Delegated Entity's materials provide patients with information about the procedure, what to

expect, the key things to do to prepare for the procedure as well as the key things to do after the procedure (including information on potential post-procedure issues to discuss with the treating provider). Currently these materials are distributed via mail. Company shall review and approve the member materials before Delegated Entity can distribute such materials to Members. All Member materials shall meet the requirements of any State, CMS, Regulatory, or Accrediting agency and shall be approved by these entities if necessary.

Additionally, Delegated Entity's care management process includes the analysis and development of evidence-based care plans in connection with Peer to Peer consultations. Delegated Entity's care management process develops these patient specific care plans for each patient and this information is shared with the provider to help providers in their dialogue with the patient, especially in the event that a particular procedure does not meet evidence-based criteria.

3.2 Appeals Program The following process will be followed for Provider Inquiries and Level 1 Appeals, unless an Affiliate's process differs in which case the Affiliates' process shall prevail:

3.2.1 A Provider submits a request for Provider Inquiry or Level 1 Appeal of a Medical Necessity Determination (hereinafter "Appeals") necessitating physician review.

3.2.2 Company will request from Delegated Entity via an encrypted connection as set forth immediately below any information and documentation needed to review the appeal.

3.2.3 Company shall identify each Appeal as either expedited or standard.

i. Twenty-Four hours (24) for an expedited appeal

ii. Two (2) business days for a standard appeal

3.2.4 Company shall complete the appeal Determination.

3.2.5 Company shall communicate final appeal decisions to Providers and to Delegated Entity within the legally required format and timeframe.

3.2.6 Company shall be responsible for all final determinations and communications to providers or members, (in accordance with their linguistic and cultural needs).

3.3 **Member Inquiries.** In those instances in which a Member (via telephone or written inquiry) contacts Delegated Entity for any other reason other than explanation or clarification regarding a UM determination, Delegated Entity shall direct the Member to Company customer service according to the Scripts.

3.4 **Delegated Entity Personnel.** In performing the Services, Delegated Entity shall use, at a minimum, the following personnel (no description of the qualifications required of such personnel contained in this subsection shall be read to limit in any way any more general qualification requirements contained elsewhere in the Agreement) Delegated Entity shall not be permitted to utilize a Chiropractor or Physical Therapist in performing any second level clinical reviews.

3.4.1. Peer Reviewers. Delegated Entity shall employ Peer Reviewers who are medical doctors, and who are board certified in their respective specialty (where applicable) with unrestricted licenses to perform the Services required under this Addendum. Each must be a graduate of an accredited professional school. Each must have been adequately trained in the Services, including, without limitation, the Medical Necessity Review services, use of Procedure Codes, the Process Documents, and use of the Scripts. Each must be fully certified to perform utilization review under State law.

3.4.2. Medical Director. Delegated Entity shall make available to Company at least one (1) Medical Director who shall, upon Company's request, meet with Company's medical directors to discuss the operation of the Services, including, without limitation, with thirty (30) days' prior notice, trips to Company by a Medical Director in order to, among other things requested by Company from time to time, consult on Company's medical policies, participate in Provider programs and participate in Company's physician/hospital advisory council.. The Medical Director shall be a medical doctor or doctor of osteopathy who is board certified in his or her respective specialty, with unrestricted licenses. The Medical Director must be a graduate of an accredited medical school with no less than ten (10) years of clinical practice. The Medical Director must have been adequately trained in the Services, including, without limitation, the Medical Necessity Review services, use of Procedure Codes, the Process Maps, and use of the Scripts.

3.4.3. At the request of a Company Affiliate, Delegated Entity may be asked to develop and maintain a listing of tiered networks, which may include providers who have been gold carded by Company from the pre-authorization process.

3.5. Company Access.

3.5.1. Company shall have all necessary access to the Services to obtain, or may request from Delegated Entity, as the case may be, any and all information collected or created by Delegated Entity with respect to any and all Medical Necessity Reviews. In the event Company requests such information from Delegated Entity, Delegated Entity shall deliver the requested information to Company by e-mail to the requestor via secure email by the end of the next business day succeeding the business day of the request.

3.5.2. Company shall provide approval to Delegated Entity of the applicable Medical Policies to the UM Services that recommend a Prior Approval or other approval applicable to the Services as of the date of this Addendum. Thereafter, Company will provide approval to Delegated Entity of any updates to the Medical Policies.

3.5.3. Company shall publish the Criteria on its website, www. Medsolutions.com or other site accessible to Delegated Entity, Providers, and Members.

3.6. **Provider Access.** Each Provider shall have access to the Criteria as found in the applicable Medical Policies on www medsolutions.com .

4. **Training.** Upon Company's request:

4.1 Prior to the implementation of any Affiliate, Delegated Entity shall provide additional training, without charge, concerning the operation of the Services to Company to the health plans, and/or health plan providers.

4.2 Delegated Entity shall permit Company personnel to attend Delegated Entity's medical advisory policy meetings or Provider continuing education seminars without charge.

4.3 Delegated Entity personnel, including Medical Directors, shall participate in in Provider meetings as they occur as reasonably requested by Company on terms and conditions mutually agreed upon by the parties.

5. **Call Center Services.** Delegated Entity shall create, maintain and operate a call center from which Delegated Entity shall receive and answer requests from Company and Providers regarding the Services and the operation of the System. Company shall have the ability to review all Company call center calls for quality assurance purposes by listening to such calls as they occur or call files when Company representatives are on site, and shall receive from Delegated Entity upon request from Company any .wav files of Provider calls with Peer Reviewers or any Delegated Entity personnel within five (5) business days of the request. Delegated Entity shall strive to meet or exceed the expectations of the Performance Guarantees outlined in this Exhibit 1A. Delegated Entity's call center hours are 8am to 6pm (all US time zones).

6. **Scripts.** Delegated Entity shall utilize Scripts established and approved by Company and Delegated Entity. Delegated Entity shall not use Scripts that have not been approved in writing by Company.

7. **Written Reponses.** Delegated Entity shall limit written responses to Providers or Members to Medical Necessity Determinations that will contain the criteria utilized for the Determination. If Delegated Entity should receive a request from a Provider or Member for a written response, Delegated Entity will direct the Provider or Member to Company customer service.

8. **Reports.** Delegated Entity shall provide the following reports in the format and frequency requested by Company or its Affiliates. Those reports that are to be delivered monthly or other frequency as requested by Affiliate or Company. Such reports shall be delivered on the 15th of the succeeding month. Those reports that are to be delivered quarterly shall be delivered on the 30th of the month succeeding the end of the quarter. Those reports that are to be delivered annually shall be delivered on the last day of quarter succeeding the end of the year. The reports shall be delivered via e-mail to Company to each respective Affiliate. Company shall provide E-mail address for each Affiliate and will work with Delegated Entity to finalize the specific report requirements, the contents of such reports and the frequency of delivery of reports, during the implementation process.

9. Criteria.

9.1 Initial Criteria. Delegated Entity shall use the most current version of the Criteria, approved by Company, in making Medical Necessity Determinations.

9.2 Alterations to the Criteria. In the event Company desires that the Criteria be altered, Company shall provide Delegated Entity with at least sixty (60) days' prior written notice of such alteration and shall provide Delegated Entity with revised Medical Policies to that effect. Delegated Entity shall implement the alteration within the sixty (60) day period and otherwise in conformance with the terms of a Change Form. In the event that Delegated Entity desires that the Criteria be altered, Delegated Entity will provide Company with altered Criteria and Medical Policy for its review and written approval. Delegated Entity may not implement altered Criteria without the prior written approval of Company. Company may alter the Criteria at any time, but may not publish or implement altered Criteria until meeting notice requirements to Delegated Entity.

9.3 Review of Criteria. Delegated Entity shall monitor, evaluate, and promptly communicate to Company regarding scientific evidence, national guidelines, and other credible sources that are relevant to Medical Policies and the Criteria.

10. Procedure Codes. Delegated Entity shall provide training to Peer Reviewers on any Company update to Procedure Codes as such updates are provided to Delegated Entity. Updates to the Procedure Codes shall not require a formal amendment to this Addendum.

11. Meetings.

11.1 Annual Meeting. During the fourth quarter of each calendar year, Delegated Entity and Company shall meet in person to discuss the operation of the Services and any improvements that can be made thereto. Without limiting the generality of the foregoing, Delegated Entity and Company shall discuss the contents of the Criteria, the reports, and any surveys performed by Company. Each party shall be responsible for its own costs related to such meeting.

11.2. Quarterly Meetings. During each quarter of each calendar year other than the fourth quarter, Delegated Entity and Company shall meet either in person or telephonically to discuss the operation of the Services and any improvements that can be made thereto. Each party shall be responsible for its own costs related to such meetings.

11.3. Ad Hoc Meetings. Delegated Entity and Company shall meet at such other times and in such other fashion to discuss the operation of the Services and any improvements that can be made thereto at either party's request. The Company Medical Director and the Account Manager shall seek to be available to one another upon request. Each party shall be responsible for its own costs related to such meetings.

11.4. Escalation. In the event of day-to-day problems in the operation of the Services, the parties will perform according to the Escalation Procedures contained in the Escalation Section of the Agreement.

12. E-mail Headings. All e-mails required by the Agreement shall contain subject lines that are appropriate, descriptive and consistent.

13. Fees. Company shall pay for the Services provided under this Addendum the Fee set forth in Exhibit 1 B attached to this Addendum.

Exhibit 1 B
Musculoskeletal Pain Management
Services and Compensation Schedule

Modality	PMPM
Pain Management – CPT codes described in Exhibit 1C	[redacted]
Physical Medicine consisting of PT, OT, ST	[redacted]

1) Payment. On or before the 15th day of each month, Company shall prepay Delegated Entity an "Administrative Fee" for provision of Delegated Entity Program services.

a) If a Member is added to Company Membership on or before the 15th day of a month, a full month's Service Fee will be due for that month. There will be no Administrative Fee due for Members added after the 15th day of the month.

b) A full month's Administrative Fee will be due for the month of termination of a Member if the Member terminates after the 15th day of the month. If a Member terminates on or before the 15th day of a month, no Administrative Fee will be due for the month of termination.

2) Adjustments. Where Company due to information delays, must make a retroactive addition or deletion to Delegated Entity's membership records, a retroactive adjustment shall be made concurrent therewith and such retroactive Administrative Fee adjustments shall not exceed sixty (60) days for each single Member. With the exception of any fraud investigation the limit to the period of time in which Delegated Entity or Company can make a claim of an overpayment or underpayment or contest an underpayment or overpayment under this Agreement is one hundred eighty (180) days from the date of the payment was made or one hundred eighty (180) days from the date of final adjudication.

The **Administrative Payment** amounts otherwise due to Delegated Entity shall be reduced as follows for Delegated Entity's failure to meet the Performance Guarantees set forth below.

1. For failure to meet any of the satisfaction measures set forth below for the previous calendar year, [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous year, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

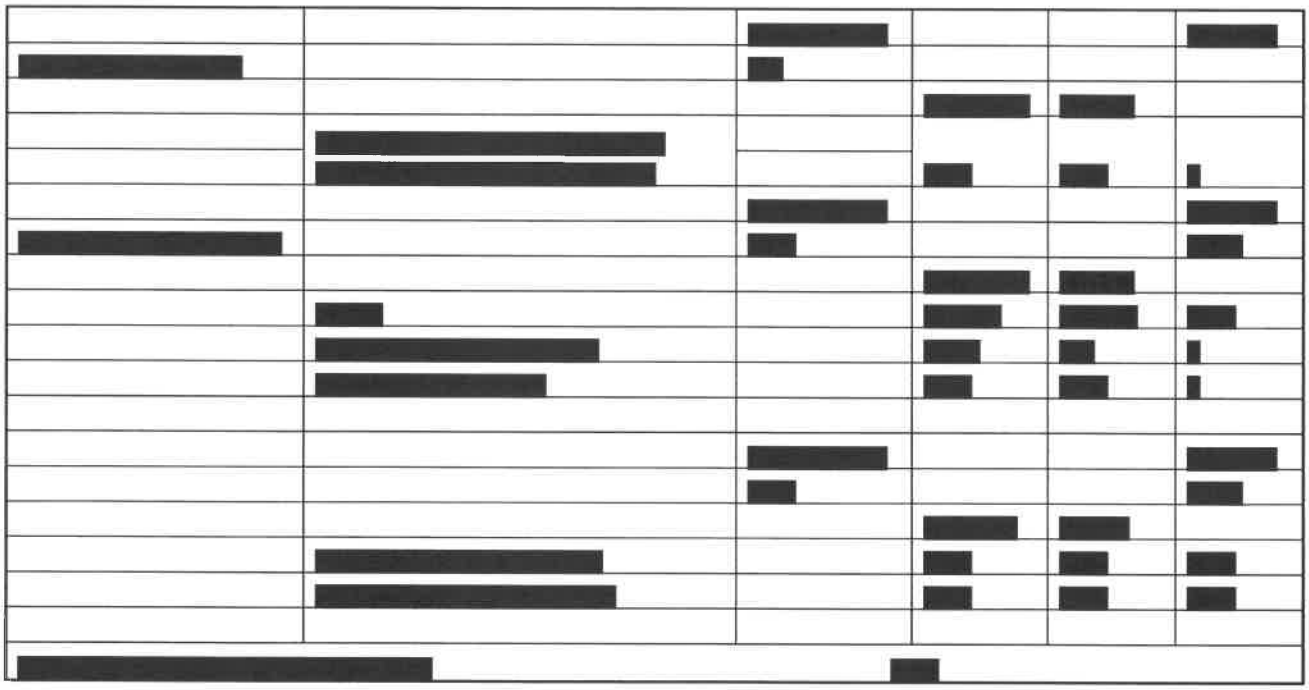
2. For failure to meet any of the call center measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.2: [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous month, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

3. For failure to meet the pre-certification turn-around-time measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.3: [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous quarter, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

4. For failure to meet the pre-certification turn-around-time overturn measures when averaged for the calendar year measured as set forth the Agreement, [redacted] of the annualized Administrative Services Fee payable by Company during the previous quarter.

5. **Example**

Delegated Entity performance results are measured after the Program Year has been completed. Those results become published ninety (90) days at the completion of the Program Year. The results at end of the Program Year show the following:



Implementation Service Guarantee

Delegated Entity, Affiliate and Company shall work together to schedule and implement the Musculoskeletal Pain Management Services program for each Company Affiliate. The parties will agree upon an implementation timeline. In the event Delegated Entity delays the agreed upon implementation date due to system failures or other circumstances solely within the control of Delegated Entity or as a result of Delegated Entity's actions or inactions, Delegated Entity shall pay Company a sum equal to [redacted],Delegated Entity delays a scheduled Affiliate implementation. Notwithstanding the above, the parties agree that Musculoskeletal Services are available at the discretion of any Company Affiliate, which may, but is not required to, implement such services in its respective market.

Exhibit 1C

HOLD FOR LIST OF CPT CODES TO INCLUDE IN MUSCULOSKELTAL PROGRAM

FOURTH AMENDMENT TO THE NATIONAL RADIOLOGY MANAGEMENT SERVICES AGREEMENT BETWEEN AETNA MEDICAID ADMINISTRATORS LLC AND MEDSOLUTIONS, INC.

This Fourth Amendment (the "Amendment") to the National Radiology Management Services Agreement (hereinafter the "Agreement") is made as of _____ (the "Effective Date"), by and between Aetna Medicaid Administrators LLC (formerly known as Schaller Anderson, LLC), on behalf of itself and its Affiliates (hereinafter "Company"); and MedSolutions, Inc., a Tennessee corporation with its principal place of business in Franklin, TN ("Delegated Entity").

WHEREAS, the parties wish to amend the Agreement to add Missouri and Michigan;

NOW, THEREFORE, in consideration of the mutual promises and undertakings contained herein, the parties agree to be legally bound as follows:

1. Exhibit A shall be modified by adding the attached Exhibit A documents for the Missouri and Michigan markets. By incorporation herein, the Parties acknowledge the inclusion of these Company Affiliates to the Agreement.

2. Exhibit B is hereby deleted in its entirety and replaced with the attached Exhibit B.

All other terms and conditions not otherwise amended herein shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

MEDSOLUTIONS, INC.

By: _____ (Signature)

Printed Name: Philip Clark

Title: General Counsel

Date: 6.16.14

Tax I.D. Number: 62-1615395

AETNA MEDICAID ADMINISTRATORS LLC

By: _____ (Signature)

Printed Name: Robert M. Kessler

Title: Secretary

Date: July 16, 2014

Medicaid Addendum – Exhibit A

MICHIGAN

With respect to the Michigan Medicaid managed care product, the following provisions shall apply when Provider renders or supplies Covered Services to Medicaid Members located in the state of Michigan and enrolled CoventryCares of Michigan's ("Health Plan's") Medicaid product.

1. Member Protection and Hold Harmless.

   a. If Health Plan utilizes co-payments, Provider shall not deny services to an individual who is eligible for the services due to the individual's inability to pay the co-payment.

   b. Provider shall look only to Health Plan for compensation for services rendered to a Member when such services are covered by the Health Plan. Provider agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against Member or person acting on behalf of Member (other than Health Plan), except to the extent that Copayment and Deductibles are specified or as permitted pursuant to coordination of benefits. Provider agrees not to maintain any action at law or in equity against a Member to collect sums that are owed by Health Plan to Provider under the terms of this Agreement, even in the event Health Plan fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this Agreement. This Section shall survive termination of this Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Member. This Section is not intended to apply to services provided after this Agreement has been terminated, except as otherwise provided in this Agreement, or to Non-Covered Services. Provider further agrees that this provision supersedes any oral or written agreement, hereinafter entered into between Provider and Member, or persons acting on Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement.

   c. Any modification, addition, or deletion to the provisions of this Section shall become effective on a date no earlier than sixty (60) days after the State Department of Financial and Insurance Services has received and approved such change.

2. Cooperation with Health Plan Activities. Provider shall cooperate with the Health Plan's quality improvement and utilization review activities.

3. Communication with Members. Providers are not prohibited from discussing treatment options with Members that may not reflect the Health Plan's position or may not be covered by Health Plan. Providers acting within the lawful scope of practice, are not prohibited, or otherwise restricted, from advising or advocating on behalf of an enrollee who is his or her patient regarding: (a) the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (b) any information the enrollee needs in order to decide among all relevant treatment options; (c) the risks, benefits, and consequences of treatment or non-treatment; (d) the enrollee's right to participate in decisions regarding his or her health care, including tbe right to refuse treatment, and to express preferences about future treatment decisions; (e) any financial arrangements between Provider and Provider; (f) Medically Necessary and appropriate care with or on behalf of an Member, including information regarding tbe nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultation or tests, regardless of benefit coverage limitations; (g) the process that Health Plan or any entity contracting with Health Plan uses or proposes to use to deny payment for a health care service; (h) the decision of any managed care plan to deny payment for a health care service; or (i) advocating on behalf of the Member in any grievance or utilization review process or Member authorization process to obtain Covered Services.

4. Aecessibility Standards: Provider shall meet the following accessibility standards as defined in the Michigan Medicaid Contract.

5. No Discrimination.

a. Health Plan may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as an "any willing provider" law, as it does not prohibit Health Plan from limiting provider participation to the extent necessary to meet the needs of the enrollees. This provision also does not interfere with measures established by the Health Plan that are designed to maintain quality and control costs consistent with the responsibility of the organization. If Health Plan declines to include providers in its network, Health Plan must give the affected providers written notice of the reason for the decision.

b. Provider agrees not to discriminate against any employee or applicant for employment, with respect to their hire, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

7. Compliance with Laws. Provider shall agree to comply with all applicable state and federal requirements, regulations and laws, including, but not limited to, rules and regulations of CMS, any other Federal agencies and any State agencies of the State(s) in which Provider practices. Provider understands and agrees that CMS and the appropriate State agencies may change or add to such requirements, laws, rules and regulations from time to time.

8. Audit, Access, Inspection. Provider agrees to permit Provider, Health Plan, any Federal or State agency having jurisdiction over Provider's provision of services to Health Plan and/or the U.S. Department of Health and Human Services and any accrediting organization to conduct periodic site evaluations of Provider's facilities, offices and records. Upon Health Plan's written request, Provider shall provide Health Plan with a copy of the written response to any questions or comments posed by the agencies listed in the preceding sentence. During regular business hours and upon reasonable notice and demand, Health Plan shall have access to, the right to audit and obtain copies of Provider Records within the possession of or reasonably accessible to, or under the control of Provider that are related to the services provided under this Agreement. Unless applicable statutes or regulations require a longer time period, Health Plan shall have such access during the term of this Agreement and for seven (7) years following its termination. All Provider Records requested by Health Plan shall be provided within no more than seven (7) days from the date such request is made, except in the case of an audit or site visit by Health Plan where records or copies of records shall be provided at the time of the audit or site visit. Provider's refusal to grant access to Provider Records as requested by Health Plan or as required by any Federal or State law or regulations shall constitute a breach of this Agreement and may result in the imposition of sanctions including termination and/or financial penalties.

9. Advanced Directives. Provider shall comply with State and federal law and Health Plan policy to enable Members to make decisions concerning their medical care, including the right to accept or refuse medical treatment and the right to formulate, at the Members option Advanced Directives.

10. Communicable Disease Reporting. Provider shall comply with all reporting requirements for communicable diseases and other health indicators.

11. Medical Records. If Provider is a Hospital, Provider must comply with all medical record requirements contained within 42 CFR 456.101 through 456.145

12. Continuation of Benefits.

a. Unless this Agreement is terminated for cause or as a result of the insolvency of Health Plan, upon termination of this Agreement, Provider shall continue to furnish Covered Services under the Agreement for a period not to exceed ninety (90) days following termination where the continuation of care is medically necessary and prudent, including without limitation, circumstances such as disability, pregnancy or life-threatening illness.

b. In the event of Health Plan's insolvency or cessation of operations, Provider shall continue to provide Covered Services to Members through the period for which Health Plan was paid on behalf of the Member or until the Member's discharge from an inpatient facility, whichever is later

c. During any such period of continued treatment, Provider shall neither charge nor hold Members financially responsible for any Covered Services rendered other than for applicable deductibles or copayments, and shall be paid for Covered Services rendered at the rate that is in effect between the parties during the period immediately preceding termination on the bases referenced herein. This subsection shall be construed in favor of the Member; survive the termination of this Agreement, regardless of the reason for termination; and supersedes any oral or written agreement to the contrary between Physician and a Member or a Member's representative.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this Exhibit A, provided, further, by executing this Exhibit A, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this Exhibit A.

MedSolutions, Inc.

By: _____

Printed Name: Philip Clark

Title: General Counsel

Date: 6.16.14

CoventryCares of Michigan, Inc.

By: _____

Printed Name: _____

Title: _____

Date: _____

Effective Date: _____

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

CoventryCares of Michigan, Inc.
1333 Gratiot Avenue
Suite 400
Detroit, MI 48207
Attn: CEO

b. In the event of Health Plan's insolvency or cessation of operations, Provider shall continue to provide Covered Services to Members through the period for which Health Plan was paid on behalf of the Member or until the Member's discharge from an inpatient facility, whichever is later

c. During any such period of continued treatment, Provider shall neither charge nor hold Members financially responsible for any Covered Services rendered other than for applicable deductibles or copayments, and shall be paid for Covered Services rendered at the rate that is in effect between the parties during the period immediately preceding termination on the bases referenced herein. This subsection shall be construed in favor of the Member; survive the termination of this Agreement, regardless of the reason for termination; and supersedes any oral or written agreement to the contrary between Physician and a Member or a Member's representative.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this Exhibit A, provided, further, by executing this Exhibit A, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this Exhibit A.

MedSolutions, Inc.

By:_____

Printed Name:_____

Title:_____

Date:_____

CoventryCares of Michigan, Inc.

By:_____

Printed Name: Robert M. Kessler

Title: Vice President and Secretary

Date: July 16, 2014

Effective Date: _____

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:

CoventryCares of Michigan, Inc.
1333 Gratiot Avenue
Suite 400
Detroit, MI 48207
Attn: CEO

PRODUCT PARTICIPATION SCHEDULE

Participation under this Agreement will include the products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Those Medicaid Plans and programs offered by Company within the State of Michigan.

EXHIBIT A

Regulatory Compliance Addendum – Missouri

If there is any conflict between the terms of this Exhibit A and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this **Exhibit A** will govern and control; provided, however, if there is any conflict between any of the terms of this Agreement, including this **Exhibit A**, and the State Contract (as defined in the Agreement), 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 provider or practitioner executing this Agreement, as identified on the first page of the Agreement.

Capitalized terms used and not otherwise defined in this **Exhibit A** shall have the meanings set forth in the Agreement or, if not defined in the Agreement, in the State Contract or under Missouri Law. The RFP referenced herein is available to Provider at http://www.dss.mo.gov/

The Parties agree as follows:

1.0 **Definitions**. The following definitions shall be incorporated into Section 1.0 of the Agreement. Any conflicting definitions in Section 1.0 of the Agreement shall be deleted in their entirety and replaced with those set forth below:

Emergency medical, behavioral health, or substance abuse services. Covered Services (inpatient and outpatient) that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an emergency medical condition.

Emergency medical condition. A medical, behavioral health, or substance use-related 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 the following: (a) Placing the physical or behavioral health of an individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) Serious impairment to bodily functions; (c) Serious dysfunction of any bodily organ or part; (d) Serious harm to self or others due to an alcohol or drug abuse emergency; (e) Injury to self or bodily harm to others; or (f) With respect to a pregnant woman having contractions: (i) that there is inadequate time to effect a safe transfer to another hospital before delivery; or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Medically Necessary. A service shall be considered medically necessary if it (1) prevents, diagnosis, or treats a physical or behavioral health or injury; (2) is necessary for the Member to achieve age appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the Member to attain, maintain, or regain functional capacity. A service shall not be considered reasonable and medically necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered.

2.0 **Compliance with Applicable Law; State Contract; Manual, Policies and Procedures**. Provider represents and warrants that it shall comply, and take all steps necessary to cause such employees, independent contractors and subcontractors to comply, with all applicable federal and state laws, rules and regulations and to perform all requirements applicable to Government Programs, including without limitation, Missouri State Regulation, 19 CSR 10-2.010, Civil Rights Requirements; Missouri Governor's E.O. #94-03 (excluding Article II due to its repeal); Missouri Governor's E.O. #05-30; the relevant provisions RSMo Sections 191.331, 285.530, 376.383, and 376.384, as amended from time to time; applicable State Agency directives; the applicable provisions of the State Contract; Company's Provider Manual, as amended from time to time; and the applicable Company policies and procedures corresponding to the MO HealthNet program. Provider acknowledges it has received a copy of the Provider Manual and such policies and procedures.

3.0 **MO HealthNet Required Provisions**. The following provisions are either required by or otherwise contained in the State Contract:

3.1 Provider shall release to Company any information necessary for Company to perform any of its obligations under the State Contract, including without limitation, compliance with all reporting requirements (e.g., encounter data reporting requirements), timely payment requirements, and quality assessment requirements.

3.2 Provider may challenge or appeal the failure of Company to cover a service, in accordance with the terms of the Agreement and the applicable policies and procedures.

3.3 Provider's facilities and records shall be open to inspection by Company and appropriate federal and state agencies, including without limitation, the State Agency. The medical records, or copies thereof, shall be provided to Company by Provider, upon request, for transfer to subsequent subcontractors for review by the State Agency.

3.4 Provider will maintain comprehensive medical records for each Member for whom services are provided for a minimum of seven years from the date of when the last professional service was provided or such longer period as may be required by law.

3.5 When no Member co-payment is required, Provider shall look solely to Company for compensation for services provided to such Member.

3.6 Provider and Company will not enter into, and will prohibit, any financial incentive arrangement to induce Provider to limit the provision of medically necessary services to Members. All financial incentive arrangements, if any, shall be set forth in writing and included in the Agreement or this Addendum. In the event of a change to these financial incentive arrangements, Provider shall immediately notify Company of such change so Company can meet its requirement to notify the State Agency.

3.7 Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations. Company may not prohibit, or otherwise restrict Provider, acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient:

1) For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
2) For any information the Member needs in order to decide among all relevant treatment options.
3) For the risks, benefits, and consequences of treatment or non-treatment.
4) For 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.

3.8 Provider shall not conduct or participate in health plan eligibility, enrollment, disenrollment, transfer, or opt out activities. Provider shall not influence a Member's enrollment. Prohibited activities include:

1) Requiring or encouraging the Member to apply for an assistance category not included in MO HealthNet Managed Care;
2) Requiring or encouraging the Member and/or guardian to use the opt out provision as an option in lieu of delivering health plan benefits;
3) Mailing or faxing health plan enrollment forms;
4) Aiding the Member in filling out health plan enrollment forms;
5) Photocopying blank health plan enrollment forms for potential Members;
6) Distributing blank health plan enrollment forms;
7) Participating in three way calls to the MO HealthNet Managed Care enrollment helpline;

8) Suggesting a Member transfer to another health plan; or
9) Other activities in which Provider is engaged in to enroll a Member in a particular health plan or in any way assisting a Member to enroll in a health plan.

3.9 If Provider is a federally qualified health center (FQHC) or rural health clinic (RHC) that may provide services to Members under a prepayment arrangement, the State Agency shall reimburse Provider 100% of its reasonable cost for Covered Services.

3.10 If Provider is a hospital, Provider will notify Company of births where the mother is a Member. [Company or Provider] is responsible for notifying the Family Support Division of the birth.

3.11 For contracted services, Company and Provider shall follow the claim processing requirements set forth by RSMo 376.383 and 376.384, as amended from time to time.

3.12 Notwithstanding any other provision herein, termination of the Agreement shall be subject to and in accordance with applicable federal and state laws and regulations, as amended, and policy.

3.13 In the event of Provider's insolvency or other cessation of operations, Covered Services to Members shall continue through the period for which a capitation payment has been made to Company or until the Member's discharge from an inpatient facility, whichever time is greater.

3.14 Company and Provider shall establish reasonable timely filing requirements for claims to be filed by Provider for reimbursement. Provider shall inform its provider network and any subcontractors of the timely filing requirements. Provider shall establish reasonable reporting of encounters to Company in sufficient detail to meet Company's encounter data reporting requirements.

3.15 Company may terminate or revoke the Agreement or impose other sanctions if Company or State Agency determines the Provider's performance is inadequate.

3.16 Company agrees and understands that consumer protection shall be integral to the MO HealthNet Managed Care Program. Provider shall comply with the consumer protection provisions outlined in the MO HealthNet Managed Care Marketing and Member Education Guidelines, described in more detail in the State Contract.

3.17 Each Member shall be entitled to one free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

3.18 National Provider Identifier. Provider shall have a national provider identifier (NPI).

3.19 Cultural Competency. Provider and its staff shall provide to Members effective, understandable, and respectful care in a manner compatible with their cultural health beliefs and practices and preferred language.

3.20 No Exclusive Relationship. Nothing in the Agreement or this Addendum shall constitute or be deemed to (a) prohibit Provider from contracting with another health plan, (b) prohibit Company from contracting with other providers, or (c) otherwise create an exclusive relationship with Provider.

3.21 Membership Capacity. Provider shall report on the number of members they will take as patients and report to Company when they have reached eighty-five (85%) of capacity.

3.22 Primary Care Provider Responsibilities. If Provider is a primary care provider, primary care provider team or primary care clinic, Provider shall be responsible for the following with respect to each Member assigned to Provider: (a) maintaining continuity of each Member's health care; (b) making referrals for specialty care and other medically necessary services to both in-network and out-of-network

providers; (c) working with Company case managers in developing plans of care for members receiving case management services; (d) conducting a behavioral health screen to determine whether the Member needs behavioral health services; and (e) maintaining a comprehensive current medical record for the Member, including documentation of all services provided to the Member by the Provider, as well as any specialty or referral services, diagnostic reports, physical and behavioral health screens, etc. If Provider is a primary care clinic, Provider shall maintain a centralized medical record on each Member enrolled with the Provider.

3.23 Specialist as Primary Care Provider. If Provider is a specialist serving as a primary care provider for a Member with a disabling condition or chronic condition which requires ongoing care from a specialist, Provider agrees to accept in writing the Member as a primary care patient and assume the applicable responsibilities set forth in the State Contract.

3.24 Mainstreaming. Provider shall accept members for treatment, and Provider shall not intentionally segregate Members in any way from other persons receiving services. Providers shall provide Covered Services to Members without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following: (a) denying or not providing to a Member any Covered Services or availability of a facility; (b) providing a Member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other Members, other public or private patients, or the public at large; (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any covered service.

3.25 Appointment Standards. Provider shall ensure that waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments do not exceed one hour from scheduled appointment time. Provider further agrees to abide by the Company's policies and procedures relating to appointment standards.

3.26 Behavioral Health and Substance Abuse In-Network Self Referrals. If Provider is a behavioral health or substance abuse provider, Provider shall complete a health status screen, at the initial point of contact and as part of the re-assessment process for Members in treatment. If Provider is a behavioral health or substance abuse provider, Provider shall refer Members with physical health conditions (as indicated by the screen) to their primary care provider for evaluation and treatment of the physical health condition.

3.27 No Balance Billing. Provider shall accept payment from Company as payment in full (no balance billing) and shall not collect payment from Members except for: (1) applicable MO HealthNet cost sharing amounts; and (2) when services are not in the comprehensive benefit package and, prior to providing the services, Provider informed the Member that the services were not covered. Provider shall inform the Member of the non-covered service and have the member acknowledge the information. If the Member still requests the service, Provider shall obtain such acknowledgement in writing (a private pay agreement) prior to rendering the service. Regardless of any understanding worked out between Provider and the Member about private payment, once Provider bills Company for the service that has been provided, the prior arrangement with the Member becomes null and void.

3.28 Retroactive Eligibility Period. Except for newborns, Company shall not be responsible for any payments owed to Provider for services rendered prior to a Member's enrollment with Company, even if the date of service fell within an established period of retroactive MO HealthNet eligibility.

3.29 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). If Provider is a FQHC or RHC, PHP shall fully comply with the State Agency's payment and billing systems, and provide the State Agency with all cost reporting information required by the State Agency to verify reasonable costs and apply applicable reasonable cost reimbursement principles. If Provider is a FQHC or RHC, Provider shall bill its usual and customary amount for all payor classes. If Provider is a FQHC or RHC,

Provider acknowledges and agrees that health plan records applicable to Provider are subject to audit by the State Agency or its contracted agent.

3.30 Physician Incentive Plan (PIP) Requirements. If Company establishes a physician incentive plan (PIP) pursuant to federal and state regulations, including 42 CFR §422.208, 422.210 and 438.6, Provider shall comply with all PIP regulations within the scope of incentive plans for Provider's provision of services to Medicare of Mo HealthNet managed care members.

3.31 Release for Ethical Reasons. Nothing in the Agreement or this Addendum shall be deemed to (a) require Provider to perform any treatment or procedure which is contrary to Provider's conscience, religious beliefs, or ethical principles or policies, or (b) prohibit Provider from making a referral to another health care provider licensed to provide care appropriate to the Member's medical condition.]

3.32 Special Supplemental Nutrition for Women, Infants and Children (WIC) Program. Provider shall document and refer eligible Members for WIC services. As part of the initial assessment of Members, and as a part of the initial evaluation of newly pregnant women, Provider shall provide and document the referral of pregnant, breast-feeding, or postpartum women, or a parent/guardian of a child under the age of five, as indicated, to the WIC Program.

3.33 Contracted Health Plans. Provider shall provide equal representation of all contracted health plans and shall not favor one health plan over another in displayed information; however, Provider may display brochures and other materials from one health plan even though all health plans have not provided similar materials. Provider shall provide Company, upon request by the Government Sponsor or state agency, all materials Provider uses to advise members of the health plans with which it has contracts. Approved materials include: (1) a list of all health plans with which Provider has contracts; (2) a letter to previous fee-for-service recipients who may be eligible for MO HealthNet Managed Care, informing them of all health plan(s) with which Provider has contracted; (3) a display of all contracted health plan provided marketing and health education materials in an equal fashion; (4) a listing of all contracted health plans phone numbers; and (5) displaying enrollment helpline phone numbers.

3.34 Medical Records. In accordance with Senate Bill No. 1024, enacted by the General Assembly of the State of Missouri, Section A., Chapter 334, RSMo, amended to be known as Section 334.097, if Provider is a physician, Provider shall maintain an adequate and complete medical record for each Member and may maintain electronic records provided the record keeping format is capable of being printed for review. An adequate and complete medical record shall include documentation of the following information: (a) identification of the Member, including name, birth date, address and telephone number; (b) the date(s) the Member was seen; (c) the current status of the Member, including the reason for the visit; (d) observation of pertinent physical findings; (e) assessment and clinical impression of diagnosis; (f) plan for care and treatment, or additional consultations or diagnostic testing, if necessary (if treatment includes medical, Provider shall include in the medical record the medication and dosage of any medication prescribed, dispensed, or administered; and (g) any informed consent for office procedures. Provider shall maintain medical records in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated. If Provider is a primary care provider and a Member changes primary care providers, upon request, Provider shall forward a Member's medical records or copies of medical records to the new primary care provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

3.35 Company Disputes With Providers. All disputes between Company and Provider shall be solely between Provider and Company. Provider shall indemnify, defend, save, and hold harmless Company and its officers, employees, and agents from any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of the Agreement because of any breach of the Agreement by Provider, Provider's subcontractors, agents, or employees, including without limitation, any negligent or wrongful acts, occurrence or omission of commission or negligence of the Provider, Provider's subcontractors, agents, providers, or employees.

3.36 Access to Premises; Cooperation with Investigations. During normal business hours (defined as 8:00 a.m. through 5:00 p.m., Monday through Friday, except State designated holidays), Provider shall allow duly authorized agents or representatives of the Federal or State government access to Provider's premises to inspect, audit, monitor, or otherwise evaluate the performance of Provider. Provider shall cooperate fully in any State reviews or investigations and in any subsequent legal action, and any corrective actions implemented by Company in instances of fraud and abuse detected by the State Agency, or other authorized agencies or entities.

3.37 Identification of Debarred Individuals or Excluded Providers. Provider represents and warrants that Provider has not had Office of Inspector General (OIG) sanctions, failed to renew any license or certification registration, had a revoked professional license or certification, or been terminated by the State Agency. Provider shall immediately notify Company in the event that Provider or any provider providing services through Provider becomes subject to Office of Inspector General (OIG) sanctions, fails to renew any license or certification registration, has a revoked professional license or certification, or is terminated by the State Agency.

3.38 Second Opinions. Provider will cooperate with Company, by making recommendations, referrals and requests for prior authorization (if required) in accordance with Company's Policies, to facilitate Members' obtaining second or third opinions, if such opinions are Covered Services or required under Member's Plan. Company shall arrange for Members to obtain second opinions out of network at no more cost to Members than if the service was obtained in-network.

4.0 **Missouri State Regulatory Requirements**. The following provisions are required by or otherwise contained in state law:

4.1 Sections 4.3.2 and 6.5.2 of the Agreement shall: (1) survive the termination of the contract regardless of the reason for termination, including the insolvency of the Company; and (2) supersede any oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by Sections 4.3.2 and 6.5.2 of the Agreement.

4.2 In no event shall Provider collect or attempt to collect from a Member any money owed to the Provider by the Company nor shall Provider collect or attempt to collect from a Member any money in excess of the coinsurance, co-payments or deductibles.

4.3 Nothing in the Agreement or this Addendum shall be deemed to (a) require Provider to use a hospitalist (a physician who becomes a physician of record at a hospital for a patient of a participating provider and who may return the care of the patient to the participating provider at the end of the hospitalization); or (b) constitute an offer of inducement under the Plan to Provider to provide less than medically necessary services to a Member; or (c) prohibit a Provider from advocating in good faith on behalf of a Member within the utilization review or grievance processes established by Company or a person contracting with Company.

4.4 Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care but shall not disclose individual identities, or investigating the grievances or complaints of Members, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records

4.5 When Company or Provider terminates the Agreement without cause, the written notice shall include an explanation of why the contract is being terminated. Within fifteen (15) working days of the date that Provider either gives or receives notice of termination for any reason, Provider shall supply Company with a list of those patients of Provider that are covered by a plan of the health carrier.

4.6 Either Party to the Agreement may exercise a right of nonrenewal at the expiration of the contract period set forth therein or upon sixty (60) days notice to the other Party and such nonrenewal shall be

deemed a termination under Article 6 of the Agreement; provided, however, that any nonrenewal shall not constitute a termination for purposes of RSMo §354.609.

4.7 Company shall not terminate the Agreement solely or in part because Provider in good faith: (1) advocates on behalf of a Member; (2) files a complaint against Company; (3) appeals a decision of Company; (4) provides information or files a report with the Missouri Department of Insurance, Financial Institutions and Professional Registration; or (5) requests a hearing or review pursuant to the Agreement or RSMo §354.609.

4.8 Provider shall provide continuation of care to Members for a period of up to ninety (90) days when Provider terminates the Agreement or the Agreement is terminated by Company where the continuation of care is medically necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness. Under such circumstances, Member shall not be liable to Provider for any amounts owed for medical care other than deductibles or co-payment amounts specified in the Agreement. In the event the Agreement is terminated and Provider is authorized to continue treating a Member pursuant to this section, the Company is obligated to pay Provider at the previously contracted rate for services provided to Member. [RSMo §354.612] In the event a practitioner's contract is discontinued, Company shall allow affected Members continued access to the practitioner, as follows. Continuation of treatment through the current period of active treatment, or for up to ninety (90) calendar days whichever is less, for Members undergoing active treatment for a chronic or acute medical condition. Continuation of care through the postpartum period for Members in their second or third trimester of pregnancy.

4.9 Notwithstanding any provision to the contrary, Company shall pay the Provider in the time frame set forth in RSMo §376.383.

4.10 Notwithstanding legitimate and medically based referral patterns, neither Party shall act in a manner that unreasonably restricts an enrollee's access to the entire network.

4.11 Provider acknowledges that provider has either had an opportunity to review this Agreement for thirty (30) days prior to execution, or hereby waives such thirty (30) day review period.

4.12 Notwithstanding anything to the contrary in the Agreement, Company reserves the right to derogate from AMA Current Procedural Terminology to conform to state-recognized coding structures.

4.13 State of Missouri Hold Harmless. The State of Missouri shall be held harmless, indemnified, and saved from and against any and all claims of damage, loss and cost (including attorney fees) of any kind related to this Agreement.

5.0 **Accreditation and Quality of Care Requirements**.

5.1 Member Protections. By way of emphasis, but not limitation, certain clauses of the Agreement are reproduced or amplified here:

5.1.1 Provider "may freely communicate **with patients about their treatment options, regardless of benefit coverage limitations." [Agreement 5.5.1]**

5.1.2 Provider agrees to provide services "with the same degree of care and skill as customarily provided" to patients who are not Members, and "agree(s) that Members and non-Members should be treated equitably." As such, hours of operation offered to Company Members shall be no less than those hours of operation offered to commercial members. [Agreement 2.2]

5.2 In addition and by way of supplement to any obligations of Provider upon termination specified in the Agreement, upon termination or non-renewal of this Agreement for any reason, other than termination by Company in accordance with Section 6.4, Provider shall, at a minimum, remain obligated at Company's request to provide Covered Services through the current period of active treatment, or for up to ninety (90) calendar days whichever is less, for Members undergoing active treatment for a chronic or acute medical condition, and through the postpartum period for

Members in their second or third trimester of pregnancy.

5.3 Coordination between Medical and Behavioral Health Providers. If applicable, for purposes of coordinating between medical and behavioral health providers, Provider shall: i) comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including obtaining any required written member consents to disclose confidential medical records; ii) make referrals for medical, social, vocational, education or human services when a need for such service is identified through assessment; iii) provide health records if requested by the medical or behavioral health provider; iv) notify the medical or behavioral health provider of all prescriptions, and when deemed advisable, check with the medical or behavioral health provider before prescribing medication; v) make certain medical and behavioral health clinicians have complete, up-to-date record of medications; vi) be available to the medical or behavioral health provider on a timely basis for consultations; and vii) otherwise cooperate with Company to coordinate the provision of medical and behavioral health services with the appropriate provider.

5.4 Provider shall cooperate with Company's quality improvement activities, including Federal and state regulatory requirements and accreditation requirements. Company shall have access to Provider medical records, to the extent permitted by applicable law. Provider shall maintain the confidentiality of Member information and records in accordance with this Agreement and applicable law. This paragraph is stated by way of emphasis, but not limitation, to the Agreement.

5.5 In order to ensure orderly implementation of new Policies mandated by Government Sponsor or applicable law in a manner that does not disrupt quality of care, Company shall implement such Policies only once its systems and processes are updated and personnel appropriately trained. Nevertheless, the Policies shall ultimately be implemented retroactively to Government Sponsor's effective date when mandated by Government Sponsor or applicable law.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.	**HealthCare USA of Missouri**
By: _____	By: _____
Printed Name: Philip Clark	Printed Name: _____
Title: General Counsel	Title: _____
Date: 6/16/14	Date: _____
	Effective Date: _____

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:
HealthCare USA of Missouri, LLC
10 South Broadway
Suite 1200
St. Louis, MO 63102

Members in their second or third trimester of pregnancy.

5.3 Coordination between Medical and Behavioral Health Providers. If applicable, for purposes of coordinating between medical and behavioral health providers, Provider shall: i) comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including obtaining any required written member consents to disclose confidential medical records; ii) make referrals for medical, social, vocational, education or human services when a need for such service is identified through assessment; iii) provide health records if requested by the medical or behavioral health provider; iv) notify the medical or behavioral health provider of all prescriptions, and when deemed advisable, check with the medical or behavioral health provider before prescribing medication; v) make certain medical and behavioral health clinicians have complete, up-to-date record of medications; vi) be available to the medical or behavioral health provider on a timely basis for consultations; and vii) otherwise cooperate with Company to coordinate the provision of medical and behavioral health services with the appropriate provider.

5.4 Provider shall cooperate with Company's quality improvement activities, including Federal and state regulatory requirements and accreditation requirements. Company shall have access to Provider medical records, to the extent permitted by applicable law. Provider shall maintain the confidentiality of Member information and records in accordance with this Agreement and applicable law. This paragraph is stated by way of emphasis, but not limitation, to the Agreement.

5.5 In order to ensure orderly implementation of new Policies mandated by Government Sponsor or applicable law in a manner that does not disrupt quality of care, Company shall implement such Policies only once its systems and processes are updated and personnel appropriately trained. Nevertheless, the Policies shall ultimately be implemented retroactively to Government Sponsor's effective date when mandated by Government Sponsor or applicable law.

IN WITNESS WHEREOF, the undersigned parties are authorized officers and/or representatives of each Party's applicable Affiliate with signatory authority to bind such Affiliate to the terms of this Agreement, including this **Exhibit A**, provided, further, by executing this **Exhibit A**, the Parties acknowledge and agree that each such Party desires the applicable Affiliate to be legally bound by all of the terms of this Agreement, including this **Exhibit A**.

MedSolutions, Inc.	**HealthCare USA of Missouri**
By:_____	By:_____
Printed Name:_____	Printed Name: Robert M. Kessler
Title:_____	Title: Vice President and Secretary
Date:_____	Date: July 16, 2014
	Effective Date: _____

As required by the Notices provisions of this Agreement, notices shall be sent to each Party at the following addresses:

To Provider at:

CEO
MedSolutions, Inc.
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

To Company at:
HealthCare USA of Missouri, LLC
10 South Broadway
Suite 1200
St. Louis, MO 63102

PRODUCT PARTICIPATION SCHEDULE

Participation under this Agreement will include the products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Those Medicaid Plans and programs offered by Company within the State of Missouri.

Exhibit B

Company Affiliates

including all products listed in Exhibit A

Affiliate Name	Address	City	State	Zip
Mercy Care Plans*	4350 E. Cotton Center Blvd.	Phoenix	Arizona	85040
Mercy Maricopa Integrated Care	4350 E. Cotton Center Blvd. Building D	Phoenix	Arizona	85040
Delaware Physicians Care, Incorporated*	252 Chapman Road	Newark	Delaware	19702
Aetna Better Health – Illinois	1 Wacker Drive	Chicago	Illinois	60606
Aetna Better Health – Ohio	Not yet determined	Not yet determined	Ohio	Not yet determined
Aetna Better Health Inc. (Pennsylvania)	2000 Market St., #800	Philadelphia	Pennsylvania	19103
Aetna Health Inc. (Pennsylvania) d/b/a Aetna Better Health Kids	2000 Market St., #800	Philadelphia	Pennsylvania	19103
Carillon Clinic Medicine Resources, LLC dba MajestaCare*	213 S Jefferson Suite 101	Roanoke	Virginia	24011
Maryland Physicians Care*	509 Progress Drive Suite 117	Linthicum	Maryland	21090
Aetna Better Health – New York	55 W 125th Street Suite 1300	New York	New York	10027
Aetna Better Health – New Jersey	Not yet determined	Not yet Determined	New Jersey	Not yet determined
Aetna Better Health – Texas	2777 Stemmons Freeway Suite 300	Dallas	Texas	75207
CoventryCares of Michigan	1333 Gratiot Ave Suite 400	Detroit	Michigan	48207
HealthCare USA of Missouri, LLC	10 South Broadway #1200	St. Louis	Missouri	63102

***Non-Affiliated Plans administered by Company with access to this Agreement.**

FIFTH AMENDMENT TO THE
RADIOLOGY MANAGEMENT SERVICES AGREEMENT

This Amendment ("Amendment") is dated May 1. 2015. and is between Aetna Medicaid Administrators LLC, on behalf of itself and its Affiliates ("Company"); and MedSolutions. Inc., a Tennessee corporation with its principal place of business in Franklin, TN ("Delegated Entity").

WHEREAS, Company and Delegated Entity entered into a Radiology Management Services Agreement on January 1, 2014 ("Agreement") for the provision of Utilization Management services;

WHEREAS, Company and Delegated Entity have since amended the Agreement on or around the following dates: First Amendment April 1, 2014 (Musculoskeletal Pain Management); Second and Third Amendments were never executed and are intentionally omitted; Fourth Amendment July 16. 2014 (adding Missouri and Michigan); and

WHEREAS, Company and Delegated Entity desire to amend the Agreement to include Aetna Better Health, Inc., dba Aetna Better Health of Louisiana, and all compensation and terms associated with this addition;

NOW, THEREFORE, in consideration of the mutual covenants and promises stated herein and in the Agreement, and other good and valuable consideration, Company and Delegated Entity agree as follows:

1. Exhibit 2: Compensation Schedule of the Agreement is hereby amended to add additional rows to the second table of states to include Louisiana as follows:

State (Effective Date)	Modality	TANF	CHIP	ABD	LTSS	Duals
Louisiana (05/01/2015)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

2. Exhibit A Regulatory Compliance Addendum is hereby amended to add the Louisiana Medicaid/CHIP Compliance Addendum to the Agreement. Delegated Entity shall comply with the terms of the Louisiana Medicaid/CHIP Compliance Addendum to the extent applicable to its Agreement with Company. In the event of any conflict between the terms of Exhibit A 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 Exhibit A will govern and control for Medicaid products only.

3. Exhibit B Company Affiliates is hereby deleted in its entirety and replaced with the following Exhibit B Company Affiliates.

4. All other terms and provisions of the Agreement not amended herein shall remain in full force and effect, without modification.

5. The Parties ratify and affirm the Agreement, and agree that it is in full force and effect as amended herein. In the event of any inconsistency between the terms of this Amendment and the Agreement, the terms of this Amendment shall govern and control.

Signatures on the following page

WITNESS WHEREOF, the Parties have caused this Amendment to be signed by their duly authorized officers as of the date indicated in the introductory clause.

MEDSOLUTIONS, INC.

By: _____

Printed Name: ~~Phil~~ Alan Poeninice

Title: CFO - Radiology

Date: 4.17.15

TIN: 62-1615395

NPI #: N/A

Medicaid #: N/A

Medicare #: N/A

AETNA MEDICAID ADMINISTRATORS LLC

By: _____

Printed Name: Robert M. Kessler

Title: Secretary

Date: April 9, 2015

Individual Sites Regulatory Addendum – Exhibit A
Louisiana Medicaid/CHIP Compliance Addendum

This Regulatory Compliance Addendum is incorporated by reference in the Agreement. It applies to Medicaid and CHIP products, including the Bayou Health Program and the eligible populations covered by the State Contract. This **Exhibit A** is effective as of the Effective Date of the Amendment.

If there is any conflict between the terms of this **Exhibit A** and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this **Exhibit A** will govern and control; provided, however, if there is any conflict between any of the terms of this Agreement, including this **Exhibit A**, 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 this Agreement, as identified on the first page of the Agreement.

1. DEFINITIONS

When used in this Amendment, all capitalized terms shall have the following meanings:

Bayou Health (or Bayou Health Program). The full risk-bearing MCO health care delivery system, authorized by La. R.S. 36:254 and operated by DHH under the authority of the State Plan Amendment, responsible for providing specified Medicaid core benefits and services included in the Louisiana Medicaid State Plan to Medicaid recipients.

Behavioral Health Services ("BHS"). Mental health and substance abuse services, which are provided to Enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. BHS may be basic or specialized. Basic BHS are provided in the Enrollee's PCP office by the Enrollee's PCP as part of primary care service activities, as well as those services provided in an FQHC ("Federally Qualified Health Center"). Specialized mental health services shall include, but not be limited to, services specifically defined in the Medicaid State Plan (or as otherwise authorized by the Bayou Health program) and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider to those Enrollees with a primary diagnosis of a behavioral disorder.

Children's Health Insurance Program ("CHIP"). The program created in 1997 by Title XXI of the Social Security Act and known in Louisiana as CHIP.

Claim. In addition to the provisions of this Agreement, Claim means (1) a bill or services, (2) a line item of service or (3) all services for one recipient within a bill.

Clean Claim. A Clean Claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a Claim with errors originating in a State's Claims system. It does not include a Claim from a provider who is under investigation for fraud or abuse, or a Claim under review for medical necessity.

Covered Services. Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Louisiana Medicaid State Plan.

Emergency Services. Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. § 438.114(a) and Section 1932(b)(2) of the Social Security Act and that are needed to screen, evaluate and stabilize an emergency medical condition. Services defined as such under Section 1867(e) of the Social Security Act ("anti-dumping provisions"). If an emergency medical condition exists, the MCO is obligated to pay for the Emergency Service. Coverage of Emergency Services must not include any prior authorization requirements, and the "prudent layperson" standard shall apply to both in-plan and out-of-plan coverage.

Enrollee. A Louisiana Medicaid or CHIP recipient who is currently enrolled in an MCO or other Medicaid managed care program.

Louisiana Department of Health and Hospitals ("DHH"). 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 Louisiana.

Louisiana Medicaid State Plan. The binding written agreement between DHH and CMS, which describes how the Medicaid program is administered and determines the services for which DHH will receive federal financial participation.

Managed Care Organization ("MCO"). A private entity that contracts with DHH to provide core benefits and services to Enrollees in exchange for a monthly prepaid capitated amount per Member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to La. R.S. 22:1016, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid program be regulated by DHH.

Managed Care Program. The Louisiana Medicaid program providing statewide leadership to most effectively utilize resources to promote the health and well-being of Enrollees in DHH's Bayou Health Program.

Material Changes. Material changes are changes affecting the delivery of care or services provided under the State Contract. Material changes include, but are not limited to, changes in composition of the provider network, subcontractor network, the MCO's complaint and grievance procedures; health care delivery systems, services, changes to expanded services; benefits; enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that require DHH approval prior to implementation; and the MCO's capacity to meet minimum enrollment levels. DHH shall make the final determination as to whether a change is material.

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 Record. A single complete record kept at the site of the Member's treatment(s), which documents medical or allied goods and services, including, but not limited to, outpatient and emergency medical health care services whether provided by the MCO, its subcontractor or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211.

Medically Necessary or Medical Necessity. Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) 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. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid

coverage and will be deemed "not medically necessary." Additionally, the Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by-case basis.

Member. As it relates to the Louisiana Medicaid/CHIP programs, the State Contract and this Agreement, Member refers to a Medicaid/CHIP eligible who enrolls in an MCO under the provisions of the State Contract and also refers to an "Enrollee" as defined in 42 C.F.R. § 438.10(a).

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 this Agreement, Policies include the general principles by which DHH is guided in its management of the Title XIX program, as further set forth and defined by DHH promulgations and by state and federal rules and regulations.

Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain, improve or resolve the Member's condition, pursuant to 42 C.F.R. § 422.113(c)(1) and § 438.114.

Primary Care Provider ("PCP"). An individual physician, nurse practitioner or physician assistant who accepts responsibility for the management of a Member's health care. The Primary Care Provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care) or admit the patient to a hospital.

State Contract. The written agreement between Company and DHH, the Government Sponsor, a copy of which shall be furnished to Provider upon request. 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. PROVIDER SERVICES AND OBLIGATIONS

2.1 Licensing Requirements. Provider must be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain, throughout the term of this Agreement, all necessary licenses, certifications, registrations and permits as are required to provide Covered Services or perform other activities delegated by Company. If DHH or Company discovers that Provider is not properly licensed by the appropriate authority, Provider shall immediately discontinue providing services to Members. Upon proper licensing by the appropriate authority and approval by DHH, Company may reinstate Provider to provide services to Members.

2.2 Suspension or Debarment. Provider acknowledges and understands that Company shall not execute contracts with any provider who has been excluded from participation in the Medicare and/or Medicaid programs pursuant to § 1128 (42 U.S.C. § 1320a-7) or § 1156 (42 U.S.C. § 1320 c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare programs. Provider further acknowledges that Company is prohibited from entering into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

2.3 Provider Services Requirements. Provider must provide, or arrange for the provision of, Covered Services or coverage of core benefits and services in the amount, duration and scope of core benefits and services specified in the Louisiana Medicaid State Plan, as well as all specific requirements of the State Contract, services under this Agreement to Members through the last day that this Agreement is in effect. Provider acknowledges that all final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee.

2.4 Fraud and Abuse Policies. To the extent applicable, Provider, on behalf of itself and any subcontractors, agrees to comply with applicable provisions of the State Contract and Company's Fraud and Abuse Compliance

Plan or other compliance program developed by Company to prevent, reduce, detect, correct and report known or suspected fraud, waste and abuse in the administration and delivery of health care services. Provider shall abide by all requirements of the State Contract regarding right of review and recovery by Company and DHH for possible acts of fraud, waste and abuse for services under this Agreement, including those rules governing complex reviews and potential overpayments and/or underpayments.

2.5 Byrd Anti-Lobbying Amendment. Provider further agrees to comply with the Byrd Anti-Lobbying Amendment, which provides that contractors who apply or submit bids shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. § 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier, up to the recipient (45 C.F.R. § 3).

2.6 Referrals. Provider shall adhere to Company's referral system and guidelines to ensure that services are furnished to Enrollees promptly and without compromise to care. Provider agrees to cooperate with Company with requested reporting and monitoring activities regarding referrals and ensure that documentation of specialty health care and out-of-network referrals, services and follow-up activities are included in the Medical Record maintained by the Member's PCP. Provider also agrees to adhere to Company's procedures and criteria for making referrals and coordinating care with behavioral health providers and agencies that will promote continuity, as well as, cost-effective care.

2.7 Responsibilities of Primary Care Providers. If Provider is a PCP, the PCP shall serve as the member's initial and most important point of interaction. The PCP shall also be responsible for the following:

(a) Managing and coordinating the medical and health care needs of members to assure that all Medically Necessary services are made available in a timely manner;

(b) Referring patients to subspecialist and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;

(c) Communicating with all other levels of medical care to coordinate and follow-up the care of individual patients;

(d) Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid fee-for-service ("FFS");

(e) Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care;

(f) Development of a plan of care to address risks and medical needs and other responsibilities regarding care management as set forth in Company Policies and the State Contract;

(g) Ensuring that in the process of coordinating care, each Enrollee's privacy is protected consistent with the confidentiality requirements of state law and those set forth in 45 C.F.R. Parts 160 and 164, which set forth the requirements regarding the privacy of individually identifiable health information;

(h) Providing after-hours availability to patients who need medical advice. At a minimum, PCP offices must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within thirty (30) minutes of the call;

(i) Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital; and

(j) Provide basic BHS and refer Members to the appropriate health care specialist as deemed necessary for specialized BHS.

2.8 Medically Necessary/Preventive Services. Provider may not refuse to provide medically necessary or covered preventive services to Members covered under this Agreement or the State Contract for non-medical reasons (except those services allowable under federal law for religious or moral objections). However, Provider is not required to accept or continue treatment of a patient with whom Provider feels he/she cannot establish and/or maintain a professional relationship.

2.9 Emergency Services. Provider shall render Emergency Services without the requirement of prior authorization of any kind. Provider agrees to cooperate with Company's obligations to monitor utilization of Emergency Services and correct inappropriate emergency department utilization.

2.10 Laboratory Services. If Provider performs laboratory services, Provider must meet all applicable federal and state law requirements, including the provisions of 42 CFR § 493.1 and § 493.3.

2.11 Behavioral Health Services. DHH and Company support the integration of physical services and BHS through screening and strengthening prevention/early intervention at the primary care level of care. As applicable, Provider shall utilize behavioral health screening tools and protocols consistent with industry standards. PCP and Company shall collaborate with behavioral health specialists, including but not limited to, psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, mental health rehabilitation service providers (public or private) and other specialty behavioral health providers, to ensure the provision of services to Members as specified in the Medicaid State Plan. In addition, Provider is not permitted to encourage or suggest, in any way, that Members be placed in state custody to receive medical or specialized BHS covered by DHH.

2.12 Treatment Decisions. Provider shall be familiar with the package of benefits offered by DHH set forth in the State Contract and DHH's requirement that providers make treatment decisions based upon individual medical needs. Provider must comply with DHH's requirements governing Member rights and responsibilities as set forth in State Contract, Company Policies and applicable state and federal law.

2.13 Appointment System. Provider shall abide by the appointment availability access standards for core benefits and/or expanded services, when applicable, to ensure that Members' needs are sufficiently met. Provider shall ensure that appointments are on a timely basis, as follows:

(a) Routine, non-urgent or preventive care visits scheduled within six (6) weeks;

(b) Urgent care visits within twenty-four (24) hours. Provider must provide or make arrangements, as directed by Company or through other arrangements, for a patient to obtain urgent care twenty-four (24) hours per day, seven (7) days per week;

(c) Emergent or emergency visits immediately upon presentation at a service delivery site. Emergency Services must be available at all times;

(d) Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;

(e) In office waiting times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time in the waiting room and examining room. If Provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment;

(f) Maternity Care:

(i) Initial appointment for prenatal visits for newly enrolled pregnant women, who must be treated without unreasonable delay, shall meet the following timetables from the postmark date the MCO mails the member's welcome packet:

(1) In the first trimester within fourteen (14) days;

(2) In the second trimester within seven (7) days;

(3) In the third trimester within three (3) day;

(ii) High risk pregnancies within three (3) days of identification of high risk by Company or maternity care provider, or immediately if an emergency exists;

(g) Specialty care consultation within one (1) month of referral or as clinically indicated;

(h) Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated;

(i) Follow-up to emergency department visits in accordance with emergency department attending provider discharge instructions;

(j) Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures; and

(k) Direct contact with a qualified clinical staff person must be available through a toll-free number at all times.

2.14 Insurance. Provider shall secure and maintain throughout the term of this Agreement, all necessary, and in the amounts required by the State Contract and/or Company, liability, workers' compensation and malpractice insurance or other coverage as is necessary to adequately protect Members and Company under this Agreement. Provider shall furnish Company with written verification of the existence of such coverage at all times during this Agreement. Provider shall not commence performance under this Agreement until all insurance requirements have been obtained and approved by Company.

2.15 No Interference by Company. Subject to the limitations set forth in 42 C.F.R. § 438.102(a)(2), Company agrees that it shall not prohibit or otherwise restrict Provider, acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, regardless of whether benefits for such care or treatment are provided under the State Contract, for the following:

(a) The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the Enrollee needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; and

(d) The Enrollee'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.

2.16 Required Disclosures. Provider shall comply with the disclosure provisions of 42 C.F.R. § 455, Subpart B and disclose all required information regarding significant business transactions, ownership and control information to Company, as well as otherwise required by applicable law.

2.17 Training. Provider shall participate in training sessions provided by Company to ensure that Provider, and any subcontractors, adhere to Company policies and procedures and Medicaid regulations, including all restrictions and limitations on marketing guidelines.

2.18 Covered Population. Provider shall provide services to the enrollment populations identified in and in accordance with the State Contract, as amended from time to time.

3. CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Compensation. Provider shall promptly submit accurate information needed to make payment under the terms of this Agreement, identifying the name and address of the official payee to whom payment shall be made and the method and amount of compensation. Provider shall make full disclosure of the method and amount of compensation or other consideration received from Company. In accordance with 42 CFR § 438.210(e), Provider is not compensated to provide incentives for Company to deny, limit, or discontinue medically necessary services to any Member.

3.2 Payment of Claims. Company agrees to pay 90% of all Clean Claims submitted by Provider within fifteen (15) business days of the date of receipt and 99% of all Clean Claims submitted by Provider within thirty (30) business days of the date of receipt. The date of receipt is the date that Company receives the Claim, as indicated by the date stamp on the Claim. The date of payment is the date of the check or other form of payment. Company and Provider may, by mutual agreement, establish an alternative payment schedule herein. Provider must submit all Claims for Covered Services for payment no later than one hundred and eighty (180) days from the date of service.

3.3 Capitation Arrangement Payments. With respect to payments made through a capitation arrangement, Provider shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of FFS Claims. If Provider becomes aware for any reason that he or she is not entitled to a PMPM payment for a particular Member (i.e., patient dies), Provider shall immediately notify both Company and DHH by certified mail, return receipt requested. Provider acknowledges and understands that such capitation arrangements may be subject to adjustment.

3.4 Timely Reimbursement. In the event that DHH deems Company unable to timely process and reimburse Claims, and requires Company to submit Claims for reimbursement to an alternate Claims processor, if applicable, to ensure timely reimbursement, Provider agrees to accept reimbursement at no more than the Company's contracted reimbursement rate or DHH's established FFS rate.

3.5 In-Network Reimbursement. Unless mutually agreed upon by the Parties, Providers who are in-network providers shall not be reimbursed by Company for defined core benefits and services at less than the Medicaid FFS rate in effect on the date of service or its equivalent (such as a DRG case rate).

3.6 Member Billing. Provider shall accept payment for Covered Services made by Company under the terms of this Agreement as payment-in-full and shall not solicit or accept any surety or guarantee of payment from DHH or any Member, which shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally responsible person of the Member being served. In accordance with federal law and regulations, Provider shall not bill Members any amount greater than would be owed if Company provided the services directly. To the extent cost sharing is required of a Member, Provider shall not deny services because of the individual's inability to pay. Members shall not be held liable for the costs of any and all services not covered by Company or in cases where Provider failed to obtain required authorization.

3.7 FQHC/RHC ("Rural Health Center") Reimbursement. Company shall reimburse a contracted FQHC/RHC at an amount equal to the Prospective Payment System ("PPS") rate in effect on the date of service of each encounter. As applicable, Provider agrees and understands that Company shall not enter into alternative reimbursement arrangements with FQHCs or RHCs.

3.8 Compensation for UM Activities. In accordance with federal law and regulations, any compensation to Company, entities or individuals that conduct utilization management activities is not structured so as to provide incentives for the entity, individual or Company to deny, limit or discontinue medically necessary services to any Member.

3. COMPLIANCE WITH POLICIES

4.1 Compliance with Applicable Law. Provider agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services under the Bayou Health Program, including Title VI and VII of the Civil Rights Act of 1964, the Vietnam Era Veterans' Readjustment Assistance Act of 1974, Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, Section 202 of Executive Order 11246 and all applicable requirements imposed by or pursuant to the regulations of HHS.

4.2 Reporting Communicable Diseases. Provider shall comply with the La. Admin. Code; Sanitary Code, Title 51, Part II, Chapter 1 and La. R.S. 40:4 *et seq.* by reporting all cases of communicable diseases such as tuberculosis, sexually transmitted diseases and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome infection to the state public health agency within twenty-four (24) hours of notification from the date of service.

4.3 QAPI and UM Programs. To the extent applicable to Provider, Provider shall adhere to the Quality Assessment and Performance Improvement Program ("QAPI") and Utilization Management ("UM") requirements specified by DHH and Company, including those set forth in the State Contract. Such requirements shall be incorporated into this Agreement.

4.4 Grievance System. Company will provide Provider with information regarding Company's grievance system that complies with state and federal laws, including 42 C.F.R. § 438, Subpart F. Provider agrees to adhere to the requirements of Company's grievance and appeals procedures. Provider shall comply with Company's Policies for grievance and appeal procedures as well as facilitate Member grievance and appeals and assist Members as required. No punitive action will be taken against any provider who files on behalf of a Member.

4.5 Record Keeping System. Provider shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly accepted information elements for Covered Services rendered to Members under the terms of this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed). Company, Members and their representatives shall be given access to and can request copies of Members' Medical Records to the extent and in the manner provided by La. R.S. 40:1299.96 and 45 C.F.R. § 164.524 and as subject to reasonable charges.

4.6 Maintenance of Medical Records. Provider shall maintain a unified Medical Record for each Member following Company's documentation guidelines regarding medical records, and the medical record documentation guidelines set forth in the State Contract.

4.7 Record Retention Policy. All records originated or prepared in connection with Provider's performance of its obligations under this Agreement, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by Provider in accordance with the terms and conditions of the State Contract and this Agreement. Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under this Agreement, and as further required by DHH, for a period of six (6) years after the last payment was made for services provided to a Member and retained further if the records are under review, audit, or related to any matter in litigation until the review, audit, or litigation is complete. If any litigation, claim or other actions involving the records have been initiated prior to the expiration

of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the six (6) year period, whichever is later. If Provider stores records on microfilm or microfiche, Provider shall produce, at its expense, legible hard copy records upon the request of state or federal authorities, within twenty one (21) calendar days of the request.

4.8 Medicaid Records Retention. Except for Medical Records pertaining to once-in-a-lifetime events, Provider shall retain any and all Member records (financial, medical, etc.) for a period of six (6) years after the last payment was made for Covered Services provided to a Member (or any greater period of time required by applicable federal and state law) or longer if the records are under review, audit, or related to any matter in litigation until the review, audit or litigation is complete. This requirement pertains to the retention of records for Medicaid purposes only. Other state or federal laws may require longer retention periods. Per La. R.S. 40:1299.96, providers must retain their records for at least six (6) years. These minimum record keeping periods run from the last date of treatment. After these minimum record-keeping periods, destruction of records is permitted. Provider shall ensure that any and all Member records are made available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of DHH or its authorized representative.

4.9 Access to Information and Records. Provider acknowledges and understands that state authorities, such as DHH, the State Auditor's Office and the Louisiana Attorney General's Office, shall have the right to evaluate, through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract and this Agreement, including documents related to the quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Claims submitted to Company. Such evaluation, when performed, shall be performed with the cooperation of Provider. Upon request, Provider shall assist in such review.

4.10 Program Procedures. Provider agrees to participate and cooperate in any internal and external quality assessment review, utilization management and grievance procedures established by Company, DHH and/or its designee. Provider further agrees to comply with all limitations on Provider marketing and any corrective action plan initiated by Company and/or required by DHH. Provider shall monitor and report the quality of services provided under this Agreement and, if necessary, initiate a plan of correction to improve the quality of care in accordance with that level of care which is recognized as acceptable professional practice in Provider's community and/or the standards established by Company, DHH and/or its designee.

4.11 Reports to Company. Provider shall provide and cooperate with Company to provide all reports and clinical information required for reporting purposes, including but not limited to, HEDIS, AHRQ, EPSDT, etc.

4.12 Member Information. Provider shall safeguard Member information in accordance with applicable state and federal laws and regulations and the policies and safeguards established by Company.

4.13 Notice of Legal or Administrative Actions. Provider shall provide Company with immediate notification in writing by certified mail of any litigation, investigation, administrative legal action, complaint, claim or transaction that may reasonably be considered to have a material impact on Provider's ability to provide services under this Agreement. Provider shall also provide prompt notice of any claim made against Provider by a third party, including a Member, that may result in litigation related in any way to Company's State Contract with DHH.

4.14 Reporting of Births. To the extent applicable and if Provider is a hospital, Provider must report the births of newborns within twenty-four (24) hours of birth for enrolled Members using DHH's web-based Facility Notification System.. If Provider is a hospital, Provider shall accurately register all births through the Louisiana Electronic Event System ("LEERS") administered by DHH/Vital Records Registry.

4.15 Records Upon Termination. Company and Provider recognize and agree that in the event of termination of the State Contract between Company and DHH, Provider shall immediately make available to Company or its designated representative and to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to Company's and Provider's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to DHH.

4.16 Failure to Comply with Contractual or Credentialing Requirements. In the event Provider fails to comply with specific contractual and/or credentialing requirements as set forth in this Agreement or Company Policies, Provider may be subject to monetary penalties, sanctions or reductions in payment, which shall include, but may not be limited to Provider's failure or refusal to respond to Company's request for information, the request to provide medical records, credentialing information, etc. Penalties shall be imposed at the Company's discretion or by a directive of DHH that Company impose, at a minimum, financial consequences against Provider as appropriate.

4.17 Assistance to Members. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d, *et seq.*) and 45 C.F.R. Part 80, Provider must take adequate steps, including coordination with Company, to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement.

4.18 PCP Linkages. If Provider is a PCP, the maximum number of linkages that Company may link to PCP is __n/a____. By signing this Agreement, PCP confirms that his/ her total number of Medicaid Members shall not exceed 2,500 Medicaid/CHIP lives. Non-compliance with this provision may result in sanctions, including, but not limited to, financial sanctions, transfer of Members to another PCP within the Company or termination of this Agreement.

4.19 Coding Requirements. Provider shall follow Company's requirements and guidelines for Claims coding and processing that are specific to each provider type. Company shall notify Provider ninety (90) days before implementing changes to Claims coding and processing guidelines applicable to Provider. The State and HHS may inspect and audit any financial records of Company, Provider or its subcontractors. There shall be no restrictions on the right of the state or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

4.20 Encounter Data. If Company has entered into a capitated reimbursement arrangement with Provider under the terms of this Agreement, Provider shall submit to Company all encounter data in a manner consistent with the same standards of completeness and accuracy as required for proper adjudication of FFS Claims by Company.

5. TERM AND TERMINATION

5.1 Termination for Failure to Re-credential. Provider shall be subject to re-credentialing by Company during the term of this Agreement. If Provider fails to submit all appropriate documents for re-credentialing as required under this Agreement or if Provider's re-credentialing materials are not received by Company, this Agreement may be terminated within thirty (30) days of expiration of Provider's current credentialing.

5.2 Termination for Cause. The Parties agree and understand that if this Agreement is terminated for cause, the effective date of such termination may be extended to provide adequate notice to DHH, or to otherwise comply with the requirements of the State Contract or applicable law.

5.3 Immediate Termination. Company may terminate this Agreement immediately at any time upon the following events:

(a) Provider's actions or the actions of Provider's subcontractor(s) pose a serious threat to the health of Members enrolled with Company;

(b) In the event DHH determines that Company has become financially unstable and terminates the State Contract between Company and DHH; and

(c) Provider fails to disclose any ownership changes within thirty-five (35) calendar days as required by 42 C.F.R. § 455.104.

5.4 Termination Without Cause. Either Party may terminate this Agreement without cause by providing ninety (90) days advance written notice to the other Party; however, such shorter periods as applicable under state law and/or the Bayou Health Program to Provider, where Provider is not a group or hospital.

6. GENERAL PROVISIONS

6.1 Disputes. Company and Provider shall be responsible for resolving any disputes that may arise between the Parties. The Parties agree that no dispute shall disrupt or interfere with the provisions of services to Members.

6.2 No Assignment. Provider shall not assign any of its duties and/or responsibilities under this Agreement and the State Contract without the prior written consent of MCO.

6.3 Incorporation of Changes to Laws and Regulations. This Agreement incorporates by reference all applicable federal and state laws or regulations, and revisions of such laws or regulations shall automatically be incorporated into this Agreement as they become effective. In the event that these changes or the result of such revisions to applicable federal or state law materially affect the position of either Party, Company and Provider agree to negotiate such further amendments as may be necessary to correct any inequities.

6.4 Modifications and Amendments. No modification, alteration, variation, waiver, extension of termination date, early termination of this Agreement or change of any provision of this Agreement shall be made unless such modification is reduced to writing, duly signed and attached as a written amendment to this Agreement; however, Company may provide amendments by written notification through Company bulletins, if mutually agreed to by the Parties and with prior notice to DHH.

If the modification or change constitutes a Material Change affecting Company's ability to deliver or administer health care services, prior approval is required by DHH of at least thirty (30) days in advance of the proposed change implementation. Notwithstanding the foregoing, the Parties acknowledge that this Agreement has been executed based upon a draft of the State Contract and related materials and that the provisions of such documents may be revised prior to the Effective Date. This Agreement shall be automatically amended to conform to the terms and provisions of the final State Contract and related materials. In the event of any inconsistency between the terms of this Agreement and the terms of the final requirements for provider agreements as set forth in the final State Contract and related materials, the terms of the final State Contract and the Policies shall control and take precedence.

6.5 Entire Agreement. This Agreement, including the State Contract, any DHH guidance or materials, schedules, appendices, exhibits and/or addenda (which may be provided upon request), constitutes the complete and sole contract, and all terms and conditions, 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.

6.6 Non-Discrimination. Provider and Company agree that no person, on the grounds of handicap, age, race, color, religion, sex, sexual orientation, national origin or basis of health status or need for health care services shall be excluded from participation in, or be denied benefits of the Government Program administered by Company. Provider shall post notices of non-discrimination in conspicuous places, available to all employees and applicants.

6.7 Indemnification and Hold Harmless. Unless Provider is a state agency, Provider shall indemnify, defend, protect and hold harmless DHH and any of its officers, agents and employees from:

(a) Any claims for damages or losses arising from services rendered by any contractor, person or firm performing or supplying services, materials or supplies for Provider in connection with the performance of this Agreement;

(b) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by Provider, its agents, officers, employees or contractors in the performance of this Agreement;

(c) Any claims for damages or losses resulting to any person or firm injured or damaged by Provider, its agents, officers, employees, or contractors by Provider's publication, translation, reproduction, delivery, performance, use or disposition of any data processed under this Agreement in a manner not authorized by this Agreement or by federal or state regulations or statutes;

(d) Any failure of Provider, its agents, officers, employees or contractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;

(e) Any claims for damages, losses or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims or damages specified above; and

(f) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or their agents, officers or employees, through the intentional conduct, negligence or omission of Provider, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of Provider, Company or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither Provider, Company, DHH or contractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services; provided, however, that so long as this Agreement remains in full force and effect, Provider shall be liable for the Covered Services required to be provided or arranged for in accordance with this Agreement.

DHH will provide prompt notice of any claim against it that is subject to indemnification by Provider under this Agreement. Provider may, at its sole option, assume the defense of any such claim. DHH may not settle any claim subject to indemnification hereunder without the advance written consent of Provider, which shall not be unreasonably withheld.

6.8 Conflict of Interest. Provider may not contract with Company unless such safeguards at least equal to federal safeguards (41 USC 423) are in place per the state Medicaid director letter dated December 30, 1997 and 1932 (d)(3) of the Social Security Act addressing the 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

6.9 Severability. If any provision or requirement of this Agreement, including items incorporated by reference, is determined by DHH to conflict with the State Contract between DHH and Company, such requirement shall be null and void and all other provisions shall remain in full force and effect. In addition, if the laws or regulations governing the State Contract should be amended or judicially interpreted as to render fulfillment of the State

Contract impossible or economically infeasible, such that Company is discharged from its obligations under the State Contract, Provider shall also be discharged from further obligations created under the terms of this Agreement.

6.10 Non Exclusive Clause. Nothing in this Agreement shall be construed to prohibit Provider from entering into a contract or arrangement with any other health plan or managed care entity. Nor shall anything in this Agreement be construed to prohibit Company from entering into a contract or arrangement with any other provider. Company shall not advertise or otherwise hold itself out as having an exclusive relationship with Provider or any service provider.

6.11 Transfer of Agreement. This Agreement may not be transferred by Provider without prior written consent of Company.

7. DELEGATION

7.1 Delegation. Provider shall not enter into any subsequent agreements with subcontractors for any of the work contemplated under this Agreement without Company's prior approval. In the event that duties are delegated hereunder, Company shall:

(a) Along with Provider, oversee all of subcontractor's performance for delegated activities;
(b) Ensure, along with Provider (if applicable) that subcontracts fulfill the requirements of 42 C.F.R. Part 438, as appropriate to the delegated activities;
(c) Have the right to review, approve and/or disapprove or any and all subcontracts entered into for the provision of services hereunder;
(d) Evaluate, in its discretion, subcontractor's ability to perform the activities to be delegated;
(e) Require a written agreement with subcontractor, specifying the activities and reporting responsibilities delegated to subcontractor, including revocation of or imposition of sanctions for subcontractor's inadequate performance;
(f) Identify areas of deficiencies or improvement and take corrective action; and
(g) Deny payments for provider preventable conditions, per the State Contract.

7.2 Credentialing. If applicable, this Agreement shall set forth a written description of the delegation of credentialing activities delegated to subcontractor. The subcontractor must provide assurance, at all times during this Agreement, that all medical professionals are credentialed in accordance with DHH's credentialing requirements. The Parties and subcontractor understand that DHH shall have final approval over a delegated entity. The Parties agree that subcontractor shall:

(a) Load provider files into its Claims processing system within thirty (30) calendar days of receipt;
(b) Notify Company immediately if a provider credentialing application is denied for reasons related to program integrity or otherwise limits the ability of a provider to participate;
(c) Process re-credentialing not less than once every three (3) years;
(d) Adopt policies or implement Company's policies and procedures to approve, terminate or suspend providers to ensure compliance with this Agreement and the State Contract; and
(e) Implement and/or assist with a provider dispute or appeal process.

Subcontractor agrees and understands that, pursuant to the State Contract, DHH and/or the State of Louisiana or its representative, reserved the right to contract with a single Credential Verification Organization ("CVO") under the State Contract. In such event, Provider and/or subcontractor agree that this Agreement shall be terminated concurrent with the minimum notice of ninety (90) days as provided to Company by DHH of such implementation of any CVO contract.

7.3 Audits. Provider and subcontractor agree and understand that subcontractors and delegated entities are subject to the audit requirements and the requirements for the adjudication of Claims under the State Contract.

PRODUCT PARTICIPATION SCHEDULE LOUISIANA

Provider agrees to participate in the Plans and other health benefit programs listed herein upon issuance of any required licenses and contracts to Company:

Those Louisiana Medicaid and CHIP Plans and programs offered by Company within the State of Louisiana. Includes Bayou Health, Managed Long Term Services and Supports, Behavioral Health, Basic Health Plans, Bridge Plans or other health plans offered to Medicaid-eligible enrollees.

Those Medicare plans for Medicaid enrollees offered by Company within the State of Louisiana. Includes Medicare D-SNP and integrated Medicare-Medicaid Plans.

Those Qualified Health Plans, whether purchased on the exchange or in the private market, offered by Company within the State of Louisiana.

Exhibit B

Company Affiliates
Including all products listed in Exhibit A

Affiliate Name	Address	City	State	Zip
Aetna Better Health Inc. dba Aetna Better Health of Illinois	333 W Wacker Drive, Suite 2200	Chicago	Illinois	60606
Aetna Better Health, Inc. dba Aetna Better Health of Louisiana	2400 Veterans Memorial Blvd., Suite 200	Kenner	Louisiana	70062
Aetna Better Health of Michigan Inc.	1333 Gratiot Ave, Suite 400	Detroit	Michigan	48207
HealthCare USA of Missouri L.L.C.	10 South Broadway #1200	St. Louis	Missouri	63102
Aetna Better Health Inc. dba Aetna Better Health of New Jersey	3 Independence Way, Suite 400	Princeton	New Jersey	08050
Aetna Better Health Inc. dba Aetna Better Health of Ohio	7400 West Campus Drive	New Albany	Ohio	43054
Aetna Better Health Inc. dba Aetna Better Health of Pennsylvania	2000 Market St., Suite 850	Philadelphia	Pennsylvania	19103
Aetna Health Inc. dba Aetna Better Health Kids	2000 Market St., Suite 850	Philadelphia	Pennsylvania	19103
Aetna Health Inc. dba Aetna Better Health (a Texas corporation)	2777 Stemmons Freeway Suite 300	Dallas	Texas	75207

SIXTH AMENDMENT TO THE
RADIOLOGY MANAGEMENT SERVICES AGREEMENT

This Amendment ("Amendment") is dated September 1, 2015, and is between Aetna Medicaid Administrators LLC, on behalf of itself and its Affiliates ("Company"); and MedSolutions, Inc., a Tennessee corporation with its principal place of business in Franklin, TN ("Delegated Entity").

WHEREAS, Company and Delegated Entity entered into a Radiology Management Services Agreement on January 1, 2014 ("Agreement") for the provision of Utilization Management services;

WHEREAS, Company and Delegated Entity have since amended the Agreement on or around the following dates: First Amendment April 1, 2014 (Musculoskeletal Pain Management); Second and Third Amendments were never executed and are intentionally omitted; Fourth Amendment July 16, 2014 (adding Missouri and Michigan); Fifth Amendment (adding Louisiana) May 1, 2015;

WHEREAS, Company and Delegated Entity desire to amend and restate a portion of the Services and Compensation Schedule to clarify certain reimbursement terms and dates and to add an additional Exhibit A for Ohio;

NOW, THEREFORE, in consideration of the mutual covenants and promises stated herein and in the Agreement, and other good and valuable consideration, Company and Delegated Entity agree as follows:

1. Exhibit 1B Musculoskeletal Pain Management Services and Compensation Schedule is hereby deleted in its entirety and replaced with the Exhibit 1B Musculoskeletal Pain Management Services and Compensation Schedule.

2. Exhibit 2 Compensation Schedule is hereby deleted in its entirety and replaced with the attached Exhibit 2 Compensation Schedule.

3. A new Exhibit A, Ohio Medicaid Regulatory Compliance Addendum (Risk) and Ohio Dual Eligible Compliance Addendum, is hereby appended to the Agreement and shall be effective upon the receipt of all applicable state approvals thereof.. In the event of any conflict between the terms of Exhibit A 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 Exhibit A will govern and control;

4. Exhibit B Company Affiliates is hereby deleted in its entirety and replaced with the following Exhibit B Company Affiliates.

5. A new Exhibit E, CPT Codes List, is hereby added to the Agreement.

6. Capitalized terms not otherwise defined herein shall have the meaning ascribed to them in the Agreement.

7. All other terms and provisions of the Agreement not amended herein shall remain in full force and effect, without modification.

8. The Parties ratify and affirm the Agreement, and agree that it is in full force and effect as amended herein. In the event of any inconsistency between the terms of this Amendment and the Agreement, the terms of this Amendment shall govern and control.

Signatures on the following page

IN WITNESS WHEREOF, the Parties have caused this Amendment to be signed by their duly authorized officers as of the date indicated in the introductory clause.

MEDSOLUTIONS, INC.

By: _____
(Signature)

Printed Name: Phillip S Clark

Title: General Counsel

Date: 9.23.15

Tax I.D. Number: 62-1615395

NPI #: 1992077762

Medicaid #: N/A

Medicare #: N/A

AETNA MEDICAID ADMINISTRATORS LLC

By: _____
(Signature)

Printed Name: Debra J. Bacon

Title: Chief Financial Officer

Date: September 23, 2015

Exhibit 1 B

Musculoskeletal Pain Management Services and Compensation Schedule

Modality	PMPM
Pain Management*	[redacted]
Physical Medicine consisting of PT, OT, ST	

*** Notwithstanding the rate set forth above**, beginning on February 1, 2015, **Aetna Better Health of Missouri LLC formally known as** Healthcare USA of Missouri L.L.C. and Coventry Health Care of Nebraska, Inc. d/b/a Aetna Better Health of Nebraska, Coventry Health Care of Florida, Inc., Coventry Health and Life Insurance Company d/b/a CoventryCares of Kentucky, Coventry Health Care of Virginia, Inc. d/b/a CoventryCares of Virginia and Coventry Health Care of West Virginia, Inc. d/b/a CoventryCares of West Virginia will pay [redacted] for the Pain Management Program in those markets that still operate on the Coventry IDX platform. Once these plans have migrated over to the Aetna Medicaid Administrators QNXT platform, the [redacted] rates for these plans will increase to [redacted] on a date as mutually agreed by the parties.

1) **Payment.** On or before the 15th day of each month, Company shall prepay Delegated Entity an "Administrative Fee" for provision of Delegated Entity Program services.

a) If a Member is added to Company Membership on or before the 15th day of a month, a full month's Service Fee will be due for that month. There will be no Administrative Fee due for Members added after the 15th day of the month.

b) A full month's Administrative Fee will be due for the month of termination of a Member if the Member terminates after the 15th day of the month. If a Member terminates on or before the 15th day of a month, no Administrative Fee will be due for the month of termination.

2) **Adjustments.** Where Company due to information delays, must make a retroactive addition or deletion to Delegated Entity's membership records, a retroactive adjustment shall be made concurrent therewith and such retroactive Administrative Fee adjustments shall not exceed sixty (60) days for each single Member. With the exception of any fraud investigation the limit to the period of time in which Delegated Entity or Company can make a claim of an overpayment or underpayment or contest an underpayment or overpayment under this Agreement is one hundred eighty (180) days from the date of the payment was made or one hundred eighty (180) days from the date of final adjudication.

The **Administrative Payment** amounts otherwise due to Delegated Entity shall be reduced as follows for Delegated Entity's failure to meet the Performance Guarantees set forth below.

1. For failure to meet any of the satisfaction measures set forth below for the previous calendar year, [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous year, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

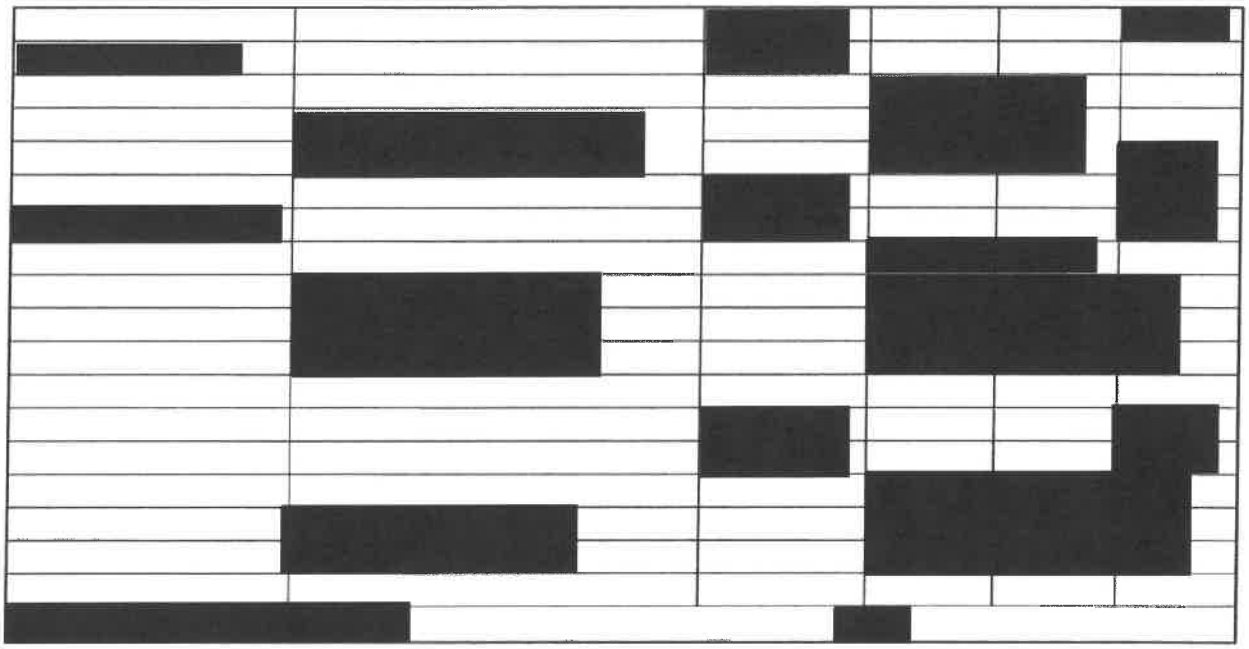
2. For failure to meet any of the call center measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.2: [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous month, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

3. For failure to meet the pre-certification turn-around-time measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.3: [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous quarter, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

4. For failure to meet the pre-certification turn-around-time overturn measures when averaged for the calendar year measured as set forth the Agreement, [redacted] of the annualized Administrative Services Fee payable by Company during the previous quarter.

5. Example

Delegated Entity performance results are measured after the Program Year has been completed. Those results become published ninety (90) days at the completion of the Program Year. The results at end of the Program Year show the following:



Implementation Service Guarantee

Delegated Entity, Affiliate and Company shall work together to schedule and implement the Musculoskeletal Pain Management Services program for each Company Affiliate. The parties will agree upon an implementation timeline. In the event Delegated Entity delays the agreed upon implementation date due to system failures or other circumstances solely within the control of Delegated Entity or as a result of Delegated Entity's actions or inactions, Delegated Entity shall pay Company a sum equal to [redacted] Delegated Entity delays a scheduled Affiliate implementation. Notwithstanding the above, the parties agree that Musculoskeletal Services are available at the discretion of any Company Affiliate, which may, but is not required to, implement such services in its respective market.

Exhibit 2: Compensation Schedule

This Compensation Schedule shall be governed by and construed in accordance with the terms and conditions of the Radiology Management Services Agreement (the "Agreement") entered into by and between Aetna Medicaid Administrators LLC and Delegated Entity. The rates described in this Exhibit 2 are payable to Affiliate beginning on the Effective Dates listed in the table below. .

Administrative Payment Amount.

The Administrative Fees by member type and modality are listed in the following table. The Administrative Fees by state are listed in the tables below.

General Rate Summary.

Modality	TANF	CHIP	ABD	LTSS	Duals	Other	SNP - dual
Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Cardiology							
Ultrasound Ultrasound OB only Ultrasound Non-OB							

- Advanced Imaging includes management of MRI, MRA, CT, CTA and PET
- Cardiology includes management of Nuclear Cardiology, Heart Catherization, Stress Echo, TTE, and TEE)
- Ultrasound includes management of OB and non-OB ultrasound, if the plan's TANF ultrasound utilization is below 150/K the price will be [redacted]

State (effective date)	Modality	TANF	CHIP	ABD	LTSS	Duals
Arizona (11/1/14)	Advanced Imaging	[redacted]				[redacted]
	Pain Management					
Illinois (3/9/15)	Advanced Imaging					
	Pain Management					
Louisiana (TBD)	Advanced Imaging					

State (effective date)	Modality	TANF	CHIP	ABD	LTSS	Dual
	Pain Management	[redacted]				
Maryland (4/1/14)	Advanced Imaging					
	Ultrasound – Non OB					
Missouri (10/1/14)	Advanced Imaging					
	Ultrasound - OB Only					
Michigan (11/1/2014)	Advanced Imaging					
	Pain Management (07/01/2015)					
Ohio (02/01/2015)	Advanced Imaging					
	Ultrasound – Non OB					
	Pain Management					
Pennsylvania (3/1/14)	Advanced Imaging					
	Ultrasound – Non OB					
	Pain Management					
Texas (09/01/2015)	Advanced Imaging					

Each month, Delegated Entity shall charge Company an Administrative Fee for the provision of Delegated Entity Program Services. The monthly Administrative Fee shall be equal to the aggregate of the applicable per Member per month amounts set forth in the table below:

1) Payment. On or before the 15th day of each month, Company shall prepay Delegated Entity an "Administrative Fee" for provision of Delegated Entity Program services.

a) If a Member is added to Company Membership on or before the 15th day of a month, a full month's Service Fee will be due for that month. There will be no Administrative Fee due for Members added after the 15th day of the month.

b) A full month's Administrative Fee will be due for the month of termination of a Member if the Member terminates after the 15th day of the month. If a Member terminates on or before the 15th day of a month, no Administrative Fee will be due for the month of termination.

2) Adjustments. Where Company due to information delays, must make a retroactive addition or deletion to Delegated Entity's membership records, a retroactive adjustment shall be made concurrent therewith and such retroactive Administrative Fee adjustments shall not exceed sixty (60) days for each single Member. With the exception of any fraud investigation the limit to the period of time in which Delegated Entity or Company can make a claim of an overpayment or underpayment or contest an underpayment or overpayment under this Agreement is one hundred eighty (180) days from the date of the payment was made or one hundred eighty (180) days from the date of final adjudication.

The Administrative Payment. Amounts otherwise due to Delegated Entity shall be reduced as follows for Delegated Entity's failure to meet the Performance Guarantees set forth in Exhibit 3.

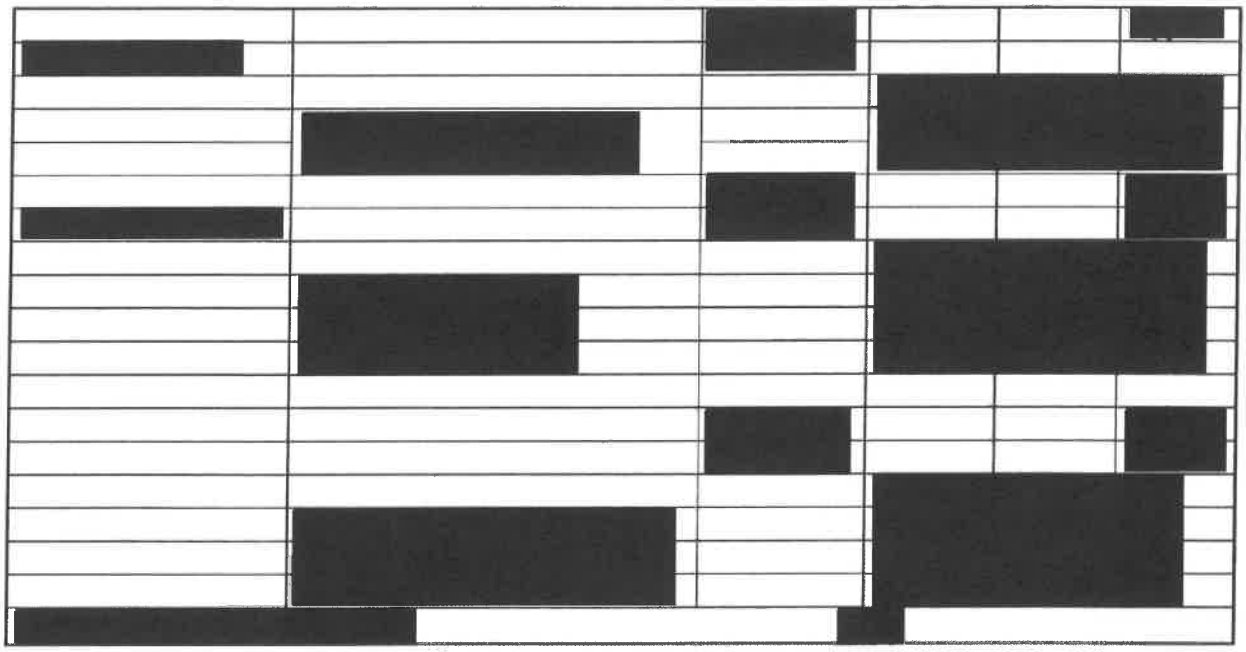
1. For failure to meet any of the satisfaction measures set forth in Exhibit 3, Section B.1 for the previous calendar year, [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous year, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

2. For failure to meet any of the call center measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.2: [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous month, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

3. For failure to meet the pre-certification turn-around-time and Adverse Determination overturn measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.3: [redacted] of the annualized Administrative Payment Amounts (excluding the Sleep Administrative Services Fee) payable by Company during the previous quarter, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

4. For failure to meet the pre-certification turn-around-time overturn measures for the Sleep Program when averaged for the calendar year measured as set forth in Exhibit 3, Section B.4: [redacted] of the annualized Sleep Administrative Services Fee payable by Company during the previous quarter.

5. Example. Delegated Entity performance results are measured after the Program Year has been completed. Those results become published ninety (90) days at the completion of the Program Year. The results at end of the Program Year show the following:



6. Implementation Costs. Delegated Entity shall pay Company the actual costs incurred by Company, but no more than [redacted] towards Company's implementation costs of the radiology management program ("Implementation Fee"). Delegated Entity shall pay a first installment of [redacted] of the Implementation Fee no later than 15 days after this Agreement's signature. Delegated Entity shall pay second and subsequent installments of the Implementation Fee, if needed, each year thereafter.

7.

Individual Sites Regulatory Addendum – Exhibit A

OHIO MEDICAID REGULATORY COMPLIANCE ADDENDUM (RISK)

This Medicaid Regulatory Compliance Addendum is incorporated by reference in the Agreement. If there is any conflict between the terms of this Addendum and any of the terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, if there is any conflict between any of the terms of this Agreement, including this Addendum, and the State Contract, then the terms of the State Contract will govern and control.

For purposes of this Addendum, the term "Provider" and shall mean the health care provider, or physician, group, facility or hospital executing this Agreement, as identified on the first page of the Agreement. For purposes of this Addendum, the terms "Company" shall mean Aetna Better Health Inc., an Ohio Corporation. In the event any of the following required Medicaid provisions are inapplicable to Provider, as construed under the State Contract and in accordance with applicable laws and regulations, such provision shall not apply. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members.

DEFINITIONS

Base Contract also known as **Agreement** means the contract between the MCP and the Provider.

MCP means a Medicaid managed care plan that has entered into a provider agreement to serve Medicaid consumers, which may include consumers enrolled in Integrated Care Delivery System (ICDS) Plans.

Medicaid means medical assistance provided under a state plan approved under Title XIX of the Social Security Act.

Member means a Medicaid recipient enrolled under the care management system pursuant to ORC 5111.16.

OAC means the Ohio Administrative Code.

ORC means the Ohio Revised Code.

ODJFS means the Ohio Department of Job and Family Services.

Provider means a hospital, health care facility, physician, dentist, pharmacy or otherwise licensed, certified, or other appropriate individual or entity, which is authorized to or may be entitled to reimbursement for health care services rendered to an MCP's member.

PROVISIONS

The provisions of this Addendum supersede any language to the contrary which may appear elsewhere in the Base Contract.

Participating providers providing health care services to Aetna Better Health Inc.'s members enrolled pursuant to a Medicaid Agreement agree to abide by all of the following specific terms:

1. Provider agrees that with the exception of any member co-payments the MCP has elected to implement in accordance with OAC rule 5101:3-26-12, the MCP's payment constitutes payment in full for any covered service and will not charge the member or ODJFS any co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise. This agreement does not prohibit Nursing Facilities (NFs) from collecting patient liability payments from members as specified in OAC rule 5101: 1-39-24 or Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) from submitting claims for supplemental payments to ODJFS as specified in OAC rules 5101:3-28-07 and 5101:3-16-05.
    A. MCP shall notify the provider whether MCP has elected to implement any member co-payments and if applicable under what circumstances member co-payments will be imposed in accordance with OAC rule 5101:3-26-12.

    B. Provider agrees that member notification regarding any applicable co-payment amounts must be carried out in accordance with OAC rule 5101:3-26-12.

2. Provider agrees not to hold liable ODJFS and the member in the event that the MCP cannot or will not pay for covered services performed by the provider pursuant to the Base Contract with the exception that:

   A. FQHCs and RHCs may be reimbursed by ODJFS in the event of MCP insolvency pursuant to Section 1902(bb) of the Social Security Act,

   B. The provider may bill the member when the MCP has denied prior authorization or referral for the services and the following conditions are met:

      i. The member was notified by the provider of the financial liability in advance of service delivery;

      ii. The notification by the provider was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose; and

      iii. The notification is dated and signed by the member.

3. Provider agrees to cooperate with the MCP's quality assessment and performance improvement (QAPI) program in all the MCP's provider subcontracts and employment agreements for physician and non-physician providers.

4. The MCP shall disseminate written policies that include detailed information about the False Claims Act and other provisions named in 42 U.S.C. Section 1396a(a)(68), any related State laws pertaining to civil or criminal penalties, whistleblower protections under such laws, as well as the MCP's policies and procedures for detecting and preventing fraud, waste and abuse; and the provider agrees to abide by the MCP's written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.

5. Provider agrees to cooperate with the ODJFS external quality review as described in OAC Division 5101:3, including rule 5101:3-26-07.

6. The terms of the Base Contract relating to the beginning date and expiration date or automatic renewal clause, as well as the applicable methods of extension, renegotiation and termination apply to this Addendum.

7. Notwithstanding item 6 of this Addendum, the MCP must give the provider at least sixty days prior notice for the nonrenewal or termination of the Base Contract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the Base Contract be terminated sooner.

8. Notwithstanding item 6 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:

   A. The provider gives the MCP at least sixty days prior notice for the nonrenewal or termination of the Base Contract. The effective date for the nonrenewal or termination must be the last day of the month; or

   B. ODJFS has proposed action in accordance with OAC Division 5101:3, including rule 5101:3-26-10(G), regardless of whether the action is appealed. The provider's nonrenewal or termination notice must be received by the MCP within fifteen working days prior to the end of the month in which the provider is proposing nonrenewal or termination. If the notice is not received by this date, the provider must extend the nonrenewal or termination date to the last day of the subsequent month

9. The procedures to be employed upon the ending, nonrenewal, or termination specified in the Base Contract, apply to this Addendum including an agreement to promptly supply all records necessary for the settlement of outstanding claims.

10. Notwithstanding Items 7 and 8 of this Addendum, in the event of a hospital provider's proposed non-renewal or termination of the Base Contract, the hospital provider agrees to notify in writing all providers who have admitting privileges at the hospital of the impending non-renewal or termination of the Base Contract and the last date the hospital will provide services to members under the Base Contract. This notice must be sent at least forty-five days prior to the effective date of the proposed non-renewal or termination. If the hospital provider issues less than forty-five days prior notice to the MCP, the notice to providers who have admitting privileges at the hospital must be sent within one working day of the hospital provider issuing notice of non-renewal or termination of the Base Contract.

11. Provider agrees to release to the MCP any information necessary for the MCP to perform any of its obligations under the ODJFS provider agreement, including but not limited to compliance with reporting and quality assurance requirements. Provider agrees the released information will be shared with ODJFS upon request to the MCP.

12. Provider must supply, upon request, the business transaction information required under 42 C.F.R. 455.105.

13. Provider and all employees of the provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the Base Contract and provider and all employees of the provider have not been excluded from participating in federally funded health care programs.

14. If the provider is a Medicaid provider, provider must meet the qualifications specified in OAC Division 5101:3, including rule 5101:3-26-05(C).

15. All laboratory testing sites providing services to members must have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or a certificate of registration along with a CLIA identification number.

16. Home health providers must meet the eligible provider requirements specified in OAC rule Chapter 5101:3-12 and comply with the requirements for home care dependent adults as specified in section 121.36 of the Ohio Revised Code.

17. Provider agrees to serve members through the last day the Base Contract is in effect.

18. If the provider is a third party administrator (TPA), the provider agrees to include all elements of OAC rule 5101:3-26-05(D) in its subcontracts and will ensure that its subcontractors will forward information to ODJFS as requested.

19. Provider agrees to provide services as enumerated in **Attachment B** of this Addendum (within the provider's scope of practice).

15. Provider shall be compensated pursuant to the method and in the amounts specified the Services and Compensation Schedule and the **Program Participation Schedule** of the Agreement.

16. Any amendment to the Attachment B and (Schedule, Exhibit, or Appendix) specified in items 19 or 20 of the addendum must be agreed to in writing by both parties.

17. If provider is a primary care provider (PCP), provider agrees to participate in the care coordination requirements outlined in OAC Division 5101:3, including rule 5101:3-26-03.1.

18. If provider is a hospital or hospital system, the Addendum must include the completed ODJFS Hospital Services Form, Attachment C of this addendum, which specifies which services of the hospital are included in the Base Contract.

19. MCP agrees not to prohibit, or otherwise restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

    A. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

    B. Any information the member needs in order to decide among all relevant treatment options.

    C. The risks, benefits, and consequences of treatment versus non-treatment.

    D. 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.

20. Provider agrees in providing health care services to members to identify and where indicated arrange, pursuant to the mutually agreed upon procedures between the MCP and provider for the following at no cost to the member:

    A. Sign language services.

B. Oral interpretation and oral translation services.

21. MCP agrees to fulfill the provider's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the provider bills a member due to the MCP's denial of payment of a Medicaid service, as specified in OAC Division 5101:3 including rule 5101:3-26-08.4, utilizing the procedures and forms as specified in OAC rule 5101:6-2-35.

22. Provider agrees to contact the MCP's designated twenty-four-hour post-stabilization services phone line to request authorization to provide post-stabilization services in accordance with OAC Division 5101:3, including rule 5101:3-26-03(G).

23. Provider agrees not to identify the addressee as a Medicaid consumer on the outside of the envelope when contacting members by mail.

24. Provider agrees not to bill members for missed appointments.

25. Provider shall not discriminate in the delivery of services based on the member's race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

26. Provider, in performance of the subcontract or in the hiring of any employees for the performance of services under the contract, shall not by reason of race, color, religion, gender, sexual orientation, age disability, national origin, military status, genetic information, health status or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

27. Provider shall not in any manner discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the subcontract on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, health status, or ancestry.

28. Provider shall be bound by the same standards of confidentiality which apply to ODJFS and the state of Ohio as described in OAC rule 5101:1-1-03 and 45 CFR Parts 160 and 164, including standards for unauthorized uses of or disclosures of protected health information (PHI).

29. Provider agrees that their applicable facilities and records will be open to inspection by the MCP, ODJFS or its designee, or other entities as specified in OAC rule 5101:3-26-06.

30. Provider agrees that the Base Contract and Addendum are governed by, and are construed in accordance with all applicable laws, regulations, and contractual obligations of the MCP.

    A. ODJFS will notify the MCP and the MCP shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCP.

    B. This Addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.

    C. The MCP shall notify the provider of all applicable contractual obligations.

31. Provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC rule 5101:3-26.

32. Provider must retain and agrees to allow the MCP access to all member medical records for a period of not less than six years from the date of service or until any audit initiated within the six year period is completed and allow access to all record keeping, audits, financial records, and medical records to ODJFS or its designee or other entities as specified in OAC rule 5101:3-26-06.

33. Provider agrees to make patient medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the patient.

The Ohio Department of Job and Family Services permit changes to Attachments A and/or B by mutual written agreement of both parties and without renegotiation of the Base Contract or this Addendum.

As required by the Notice provision of the Agreement, notices shall be sent to the following address:

To Company at:

Aetna Better Health of Ohio
7400 West Campus Road
New Albany, OH 43054

Attachment A to Exhibit A

[NON-Primary Care Providers Only]

List all non-PCP names that have been contracted with to provide services to Medicaid Members.

PRACTICE SITE	PROVIDER NAME	SPECIALTY
1) (Practice Name) (Address) (City Zip Code) (County)	n/a	
2) (Practice Name) (Address) (City Zip Code) (County)		
3) (Practice Name) (Address) (City Zip Code) (County)		

If the practice has more than three locations or more than (5) providers at a location, please provide the requested information in a document titled "Attachment A". If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3) and the last page must be signed by the provider and the MCP.

Provider

_____

By

_____

Printed Name

_____

Title

_____

Date

Attachment B to Exhibit A

Provider agrees to provide services as enumerated below (specify below):

Ambulance transportation
Ambulatory Surgery Center
Advanced practice nurse services (specify: _____)
Chiropractic services
Dental services
Durable medical equipment (DME)
Emergency Services
Family planning services and supplies
Federally Qualified Health Center services
Home health services/Private Duty Nursing
Hospice care
Medical Imaging
Inpatient hospital services
Laboratory services
Mental health and/or substance abuse services
Nursing facility services
Obstetrical and/or gynecological services
Ophthalmology services
Outpatient hospital services
Physical and occupational therapy
Podiatry services
Pharmacy
Physician services
Primary care provider services
Renal dialysis
Rural Health Clinic services
Specialty physician services, Specify (e.g., cardiology, allergy, etc): _____
Speech and hearing services
Vision (optical) services, including eyeglasses
✓ **Other (Radiology Utilization Management Services)**

Community Behavioral Health Services (included only in the ICDS benefit package)

Pharmacological Management
Behavioral Health Assessment
Behavioral Health Counseling and Therapy
Crisis Intervention
Partial Hospitalization
Community Psychiatric Support Treatment
Ambulatory Detox
Targeted Case Management for AOD
Intensive Outpatient
Laboratory urinalysis
Med –Somatic
Methadone Administration

Home and Community Based Services (included only in the ICDS benefit package)

Out of Home Respite Services
Adult Day Health Services
Home Medical Equipment & Supplemental Adaptive & Assistive Devices
Waiver Transportation
Chore Services

- ☐ Social Work Counseling
- ☐ Emergency Response Services
- ☐ Home Modification Maintenance and Repair
- ☐ Personal Care Services
- ☐ Homemaker Services
- ☐ Waiver Nursing Services
- ☐ Home Delivered Meals
- ☐ Alternative Meals Service
- ☐ Pest Control
- ☐ Assisted Living Services
- ☐ Home Care Attendant
- ☐ Choices Home Care Attendant
- ☐ Enhanced Community Living Services
- ☐ Nutritional Consultation
- ☐ Independent Living Assistance
- ☐ Community Transportation

Individual Sites Regulatory Addendum – Exhibit A

OHIO DUAL ELIGIBLE COMPLIANCE ADDENDUM

Addendum Governing Services Provided to Medicare-Medicaid Dual-Eligible Members

This Addendum Governing Services Provided to Medicare-Medicaid Dual-Eligible Members (the "Duals Addendum") shall govern the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the *Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services, In Partnership with the State of Ohio Department of Medicaid and Aetna Better Health Inc., an Ohio Corporation*, issued on February 11, 2014 (the "Three-Way Contract"), which established and governs the program known as the MyCare Ohio Duals Demonstration (the "Demonstration"). For purposes of this Duals Addendum, Aetna Better Health Inc. d/b/a Aetna Better Health of Ohio will be referred to as "MCO" or "the MCO," and the individuals who are enrolled with the MCO under the Demonstration will be referred to as the "Beneficiaries," "Members," or "Enrollees." This Duals Addendum is incorporated by reference into the Agreement between Aetna Medicaid Administrators LLC (formerly known as Schaller Anderson, LLC) on behalf of itself and its Affiliates and the provider, vendor, contractor, or other entity executing this Agreement, as identified on the first page of the Agreement (the "Provider").

If there is any conflict between the terms of this Duals Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Duals Addendum will govern and control with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration; provided, however, that if there is any conflict between any of the terms of this Agreement, including this Duals Addendum, and the Three-Way Contract, then the terms of the Three-Way Contract will govern and control. Except as provided herein, all other provisions of the Agreement not inconsistent with this Duals Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Duals Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Three-Way Contract and the remainder of the Agreement. All headings contained in this Duals Addendum 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 Duals Addendum or the Agreement.

Provider acknowledges and agrees that all provisions of this Duals Addendum shall apply equally to any employees, independent contractors, subcontractors, downstream entities, or related entities of Provider that provide or may provide Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and Provider represents and warrants that Provider shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Duals Addendum and all applicable laws and regulations.

REQUIREMENTS FOR THE DEMONSTRATION

A. Ohio State Requirements

Provider shall comply with the requirements set forth in Exhibit A ("Regulatory Compliance Addendum—Ohio") to this Agreement with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, including the performance of any activities delegated to Provider in connection with the Three-Way Contract and the Demonstration.

B. Medicare Requirements

Without limiting any obligation of Provider under the Agreement, Provider shall comply with, and shall cause its Downstream Entities and Related Entities to comply with, the requirements set forth in this **Section B** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, including the performance of any activities delegated to Provider in connection with the Three-Way Contract and the Demonstration (the "Medicare Services"). For purposes of this **Section B**, the Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration shall collectively be referred to as the "Medicare Members," and the managed-care plan that MCO offers under the Three-Way Contract and the Demonstration shall be referred to as the "Medicare Plan." Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. 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 Services

and Compensation Schedule (or other analogous compensation schedule appended to the Agreement).

B. MCO shall not pay any amounts beyond the amounts set forth in the applicable Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement), 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 MCO 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, MCO's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. MCO 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 adjust payments to Provider for Covered Services until the earlier of (i) the discontinuation of the Medicare Payment Adjustment, or (ii) the replacement of the Medicare Payment Adjustment by a subsequent Medicare Payment Adjustment.

C. Pursuant to Section B.5.K. of this Duals Addendum, Provider certifies that the diagnosis codes submitted to MCO for Medicare Members that MCO is required to submit to CMS will be accurate, complete, and truthful (the "Certification"). Provider acknowledges and agrees that MCO may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to MCO 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, "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 (the "Medicare Statute of Limitations"). If MCO makes an overpayment or payment in error to Provider for Medicare Members, MCO 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 MCO's reasonable suspicion of fraud or other intentional misconduct.

2. ASSIGNMENT. In addition to all other rights of MCO under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Duals Addendum) may be assigned by MCO, at any time and from time to time, in whole or in part, to any other affiliate or successor in interest of MCO. At MCO's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with MCO for those products/lines of business designated by MCO 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, MCO shall provide advance written notice to Provider. In the event of a conflict between this Section and any other provision of the Agreement, the terms of this Section shall supersede and prevail.

3. EFFECT OF TERMINATION. In the event this Duals Addendum is terminated for any reason, such termination shall not constitute termination of any of MCO's other products, plans, or programs.

4. MEDICARE REQUIRED PROVISIONS. Provider agrees to comply with all of the provisions of Schedule I, attached hereto and incorporated into this Duals Addendum.

5. 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. Compliance; Cooperation. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement will be consistent and comply with MCO's obligations under the Three-Way Contract. Upon request, Provider shall immediately provide to MCO any information that is required by MCO 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 MCO that MCO, 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 MCO 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 MCO for the Medicare Plan from CMS pursuant to the Three-Way Contract are federal funds. As a result, Provider, by entering into this Agreement and the terms of this Duals 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 the Three-Way Contract terminates or MCO 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) 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 Duals Addendum, regardless of the reason for termination, including the insolvency of MCO, and shall supersede any oral or written agreement between Provider and a Medicare Member.

E. Policies, Programs & Procedures. Provider agrees to comply with MCO's policies and procedures (which MCO shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Duals Addendum, and the Three-Way Contract and Demonstration. Provider agrees to comply with MCO's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies MCO may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that an MCO 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 MCO's participation in the Three-Way Contract and Demonstration, 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 MCO to calculate Medicare medical loss ratios ("MLRs") for MCO's Medicare products and/or evidence needed by MCO 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 MCO 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 MCO 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 Three-Way Contract. 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 MCO delegates to Provider the selection of providers, MCO retains the right to approve, suspend or terminate such delegation. If MCO delegates the selection of providers, MCO will either review the credentials of medical professionals affiliated with Provider or MCO 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 and/or 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, the "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 the Medicare Plan, 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 Duals Addendum, MCO shall have the right, in its sole discretion and judgment, to terminate this Duals 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 (an "Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative, or other individual or entity) to perform any services for the Medicare Plan 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 MCO, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that MCO has the right to audit any Offshore Entity prior to the provision of Offshore Services for the Medicare Plan. 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 MCO 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 MCO and to provide MCO with all such information in such form and manner as requested by MCO. Provider agrees to immediately notify MCO if any encounter data that Provider submitted to MCO for Medicare Members is inaccurate, incomplete, or erroneous, and to cooperate with MCO to correct erroneous encounter data to ensure MCO's compliance with Medicare laws, rules and regulations and CMS instructions.

K. Certification of Data. Provider recognizes that MCO 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 MCO by its contractors and subcontractors. Provider and its subcontractors, if any, hereby certify that any such data submitted to MCO will be accurate, complete, and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by MCO.

L. Medicare Member Complaints. Provider agrees to cooperate with MCO in resolving any Medicare Member complaints related to coverage or the provision of Covered Services. MCO 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 MCO 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 the Medicare Plan. 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 MCO, 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 issued 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 MCO'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 program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare Members, 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 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 it will not collect Cost Sharing Amounts from Medicare Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the MCO'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.

P. Enrollment as Medicare Provider. To the extent that Provider prescribes drugs covered under Medicare Part D to Medicare Members who have Medicare prescription drug ("MA-PD") coverage offered by MCO, Provider agrees to comply with the requirements set forth in 42 C.F.R. § 423.120(c)(6), including without limitation the requirement that Provider be enrolled in Medicare in an approved status in order for its prescriptions to be covered under Medicare Part D.

Q. Home Infusion Drugs. The following provisions shall only apply to Provider if Provider dispenses to a Medicare Member home infusion drugs that are covered under Medicare Part D and the Medicare Member has MA-PD coverage offered by MCO ("Home Infusion Drug"):

1. With respect to Home Infusion Drugs, MCO will pay clean claims (as defined in 42 C.F.R. § 423.520(b)) submitted by Provider on behalf of Medicare Members within 14 days for electronic claims and within 30 days for claims submitted otherwise. 42 C.F.R. § 423.505(i)(3)(vi).

2. Home Infusion Drugs will be reimbursed (as applicable) in accordance with a fee schedule, or the third-party pricing source (*e.g.*, Medi-Span) otherwise agreed upon as set forth in this Agreement or Provider's agreement with MCO's Pharmacy Benefit Manager ("PBM"). 42 C.F.R. § 423.505(i)(3)(viii)(B).

3. If a prescription drug pricing standard is used for reimbursement of Home Infusion Drugs, updates to such a standard will occur not less frequently than once every 7 days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the Home Infusion Drug. 42 CFR § 423.505(i)(3)(viii)(A).

4. In accordance 42 C.F.R.§ 423.120(c)(3), Provider agrees to submit claims for Home Infusion Drugs to MCO or its PBM whenever the Medicare Member's ID card is presented or is on file at the Provider, unless the Medicare Member expressly requests that the claim not be submitted to MCO or its PBM.

5. Provider must submit claims for Home Infusion Drugs in real time by means of point of service claims adjudication systems in compliance with CMS standards. 42 C.F.R. § 423.505(b)(17).

6. Provider must provide Medicare Members with access to the negotiated prices (as defined in 42 C.F.R. § 423.100) for Home Infusion Drugs to Members. 42 C.F.R. § 423.104(g)(1).

7. Provider must charge/apply the correct cost-sharing amount to the Medicare Member for Home Infusion Drugs. 42 C.F.R. § 423.104.

8. At the time of purchase by a Medicare Member, Provider must inform the Medicare

Member of any differential between the price of the Home Infusion Drug being dispensed and the price of the lowest priced generic version of that Home Infusion Drug available from Provider, unless the Home Infusion Drug being dispensed is the lowest priced generic version of that Home Infusion Drug. 42 C.F.R. § 423.132.

9. Provider agrees to ensure that the professional services and ancillary supplies necessary for Home Infusion Drugs are in place before dispensing Home Infusion Drugs to a Medicare Member in his/her place of residence. 42 C.F.R. § 423.120(a)(4)(iii).

10. Provider agrees to provide delivery of Home Infusion Drugs within 24 hours of a Medicare Member's discharge from an acute setting, or later if so prescribed. 42 C.F.R. § 423.120(a)(4)(iv).

11. Provider shall submit to MCO (not PBM) claims for equipment, supplies, and professional services associated with Home Infusion Drugs dispensed by Provider to a Medicare Member that are covered under Medicare Part C.

6. COMPANY OBLIGATIONS.

A. Fee Schedule. MCO shall arrange for Provider to be compensated for health care services rendered to Medicare Members in accordance with Section B.1 of this Duals Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(a)(1), MCO 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 Duals Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. § 422.500.

C. From time to time MCO may designate only certain Providers to take part in the provider delivery network for a particular product benefit plan(s).

7. GENERAL PROVISIONS.

A. Termination. This Duals 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 and the Three-Way Contract. This Duals Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement and the Three-Way Contract.

B. Governing Law. This Duals Addendum shall be governed by federal laws, regulations, and agency requirements applicable to the Medicare program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare program occur, the new law, regulation, or agency requirement shall supersede to the extent required by any such later required changes.

C. Agreement Otherwise Unmodified. 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 Duals Addendum and the Agreement, the terms of this Duals Addendum shall govern and control.

D. Survival. All provisions of this Duals Addendum that 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.

C. **Requirements Under the Demonstration Three-Way Contract**

The Three-Way Contract requires that specific additional terms and conditions be incorporated into the Agreement. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the requirements set forth in this **Section C** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, including the performance of any activities delegated to Provider in connection with the Three-Way Contract and the Demonstration. With respect to the requirements set forth in this **Section C**, any capitalized terms that are used but not defined herein shall have the meanings that are ascribed to them in the Three-Way Contract. Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. The delegated activities and reporting requirements for which Provider is responsible are contained in the Agreement. Provider shall ensure that it and its downstream and related entities perform all such delegated

activities and reporting requirements in compliance with 42 C.F.R. §§ 422.504, 423.505, 438.6(I), and 438.230(b)(1), as applicable. [Appendix C, ¶ A of Three-Way Contract]

2. HHS, the Comptroller General, the Department, and their respective designees have the right to audit, evaluate, and inspect any books, contracts, computer, or other electronic systems, including medical records and documentation, of Provider and its downstream and related entities, and the foregoing rights to inspect, evaluate, and audit any pertinent information for any particular contract period shall exist for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later. [Appendix C, ¶ C of Three-Way Contract]

3. Provider and its downstream and related entities shall not hold Beneficiaries liable for payment of any fees that are the obligation of MCO. [Appendix C, ¶ D.1 of Three-Way Contract]

4. Any services or other activity performed by Provider and/or its downstream and related entities shall be performed in accordance with the MCO's contractual obligations to CMS and the Department. [Appendix C, ¶ D.2 of Three-Way Contract]

5. MCO shall revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS, the Department, or the MCO determine that Provider and/or its downstream and related entities have not performed their delegated activities or reporting requirements satisfactorily. [Appendix C, ¶ D.4 of Three-Way Contract]

6. The performance of Provider and its downstream and related entities under the Agreement will be monitored by MCO on an ongoing basis and MCO may impose corrective action as necessary. [Appendix C, ¶ D.5 of Three-Way Contract]

7. Provider and its downstream and related entities agree to safeguard Beneficiary privacy and confidentiality of Beneficiary health records. [Appendix C, ¶ D.6 of Three-Way Contract]

8. Provider and its downstream and related entities must comply with all federal and state laws, regulations, and CMS instructions. [Appendix C, ¶ D.7 of Three-Way Contract]

9. To the extent that Provider and/or its downstream and related entities provide credentialing of medical providers under the Agreement:

   A. The credentials of medical professionals affiliated with the Provider and/or its downstream and related entities will be reviewed by MCO; or

   B. The credentialing process will be reviewed and approved by MCO and MCO shall audit the credentialing process on an ongoing basis.

   [Appendix C, ¶ E of Three-Way Contract]

10. To the extent that MCO has delegated the selection of providers under the Agreement to Provider or its downstream and related entities, MCO retains the right to approve, suspend, or terminate that arrangement. [Appendix C, ¶ F of Three-Way Contract]

11. MCO shall provide a written statement to Provider of the reason or reasons for termination for cause. [Appendix C, ¶ G of Three-Way Contract]

12. MCO is obligated to pay Provider under the terms of the Agreement, which includes a prompt-payment provision that has been developed and agreed to by both MCO and Provider. [Appendix C, ¶ H.1 of Three-Way Contract]

13. Provider and its downstream and related entities shall provide all services under the Agreement in a Culturally Competent manner to all Beneficiaries, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds. [Appendix C, ¶ H.2 of Three-Way Contract]

14. Provider and its downstream and related entities shall abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. [Appendix C, ¶ H.3 of Three-Way Contract]

15. Provider and its downstream and related entities shall ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas. [Appendix C, ¶ H.4 of Three-Way Contract]

16. Provider and its downstream and related entities shall maintain Beneficiary records and information in an accurate and timely manner. [Appendix C, ¶ H.5 of Three-Way Contract]

17. Provider and its downstream and related entities shall ensure timely access by Beneficiaries to the records and information that pertain to them. [Appendix C, ¶ H.6 of Three-Way Contract]

18. Provider and its downstream and related entities shall not hold Beneficiaries liable for Medicare Part A and B cost sharing, and all Medicare Parts A and B services must be provided at zero cost-sharing to Beneficiaries. [Appendix C, ¶ H.7 of Three-Way Contract]

19. Provider and its downstream and related entities shall ensure that their EMTALA obligations are fulfilled as required by law and the Agreement and must not create any conflicts with any hospital actions required to comply with EMTALA. [Appendix C, ¶ H.8 of Three-Way Contract]

20. Provider and its downstream and related entities, including without limitation all primary care providers, shall not close or otherwise limit acceptance of Beneficiaries as patients unless the same limitations apply to all commercially insured Beneficiaries. [Appendix C, ¶ H.9 of Three-Way Contract]

21. MCO shall not refuse to contract or pay Provider for the provision of Covered Services solely because Provider has in good faith:

    (a) Communicated with or advocated on behalf of one or more of the prospective, current, or former patients of Provider or its downstream and related entities regarding the provisions, terms, or requirements of the MCO's health benefit plans as they relate to the needs of such patients; or

    (b) Communicated with one or more of the prospective, current, or former patients of Provider or its downstream and related entities with respect to the method by which such provider is compensated by the MCO for services provided to the patient.

    [Appendix C, ¶ H.10 of Three-Way Contract]

22. Provider and its downstream and related entities are not required to indemnify MCO for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against MCO based on MCO's management decisions, utilization review provisions, or other policies, guidelines, or actions. [Appendix C, ¶ H.11 of Three-Way Contract]

23. Provider and its downstream and related entities shall comply with all MCO's requirements and MCO Policies for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services. [Appendix C, ¶ H.12 of Three-Way Contract]

24. MCO shall notify Provider in writing of modifications in payments, modifications in Covered Services or modifications in MCO's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 30 calendar days before the effective date of such modification unless such other date for notice is mutually agreed upon between MCO and Provider or unless such change is mandated by CMS or the Department without 30 calendar days' prior notice. [Appendix C, ¶ H.13 of Three-Way Contract]

25. Provider must comply with all Beneficiary payment restrictions, including balance billing restrictions, and MCO may revoke or impose other specified remedies against Provider if Provider does not comply with such provisions. [Appendix C, ¶ H.14 of Three-Way Contract]

26. Provider and its downstream and related entities shall not bill Beneficiaries for charges for Covered Services other than pharmacy co-payments, if applicable. [Appendix C, ¶ H.15 of Three-Way Contract]

27. No payment shall be made by MCO to Provider, and Provider shall not seek payment from MCO, for a Provider Preventable Condition as defined in 42 C.F.R. § 447.26(b), and Provider shall, as a condition of payment from MCO, comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by MCO and/or the Department. [Section 2.7.6.2 and Appendix C, ¶ H.16 of Three-Way Contract]

28. Provider shall ensure coverage for its practice twenty-four (24) hours a day, seven (7) days a week, when medically necessary. [Section 2.8.5.3 of Three-Way Contract]

29. MCO shall monitor and ensure that all utilization management activities provided by Provider comply with all provisions of the Three-Way Contract with CMS and the Department, and Provider and its downstream and related entities shall cooperate with and utilize MCO's quality assurance program. [Section 2.11.2.2.3.2 of Three-Way Contract]

30. Provider shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. Contracts or arrangements with First Tier, Downstream and Related Entities shall not include incentive plans that include a specific payment to Provider or its downstream and related entities as an inducement to deny, reduce, delay, or limit specific, Medically Necessary Services, and (a) Provider and/or its downstream and related entities shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate, and (b) MCO shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate. [Appendix C, ¶¶ H.14 and I, and Section 5.1.7.2 of Three-Way Contract]

31. MCO shall not impose a financial risk on Provider or its downstream and related entities for the costs of medical care, services, or equipment provided or authorized by another Physician or health care provider unless such contract includes specific provisions with respect to the following:

    A. Stop-loss protection;

    B. Minimum patient population size for the Physician or Physician group; and

    C. Identification of the health care services for which the Physician or Physician group is at risk.

    [Appendix C, ¶ J of Three-Way Contract]

32. All contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites that provide services must include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. [Appendix C, ¶ K of Three-Way Contract]

33. Nothing shall be construed to restrict or limit the rights of MCO to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious nonmedical providers. [Appendix C, ¶ L of Three-Way Contract]

34. Provider shall meet all terms and requirements of the Three-Way Contract that are applicable to Provider. [Section 2.7.3.1 of Three-Way Contract]

35. Provider and its downstream and related entities shall allow MCO to access the medical records of Beneficiaries. [Section 2.7.7.1.4 of Three-Way Contract]

36. Provider will collaborate with MCO on documentation systems reporting, communications, policies, and any other matters necessary for any readiness review required under the Three-Way Contract. [Section 2.2.1.of Three-Way Contract]

37. Provider shall collaborate with MCO, as requested and required under the Three-Way Contract, on activities relating to Care Management, the Individualized Care Plan, the Centralized Enrollee Record, and the Care Management System. [Section 2.5.3 of Three-Way Contract]

38. As requested and required under the Three-Way Contract, Provider shall actively participate as a member of

the Trans-Disciplinary Care Team, and shall collaborate with the Beneficiary and other members of the Trans-Disciplinary Care Team to perform the functions and tasks that are required of the Trans-Disciplinary Care Team under the Three-Way Contract. [Section 2.5.3 of Three-Way Contract]

39. Provider must comply with the United States Supreme Court's *Olmstead* decision, which requires that Beneficiaries be served in the most integrated setting appropriate to their needs. [Section 2.5.3.4.1.1 of Three-Way Contract]

40. Provider shall be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender, and other unique needs of any minority, homeless population, Beneficiary with disabilities (both congenital and acquired disabilities), or other special population served by the MCO. [Section 2.6.1.10 of Three-Way Contract]

41. To the extent that Provider is multilingual, Provider shall understand and comply with its obligations under state or federal law to assist Beneficiaries with skilled medical interpreters and the resources that are available to assist Provider to meet these obligations. [Section 2.6.1.12 of Three-Way Contract]

42. Provider shall comply with timely access requirements pursuant to 42 C.F.R. § 438.206(c)(1). [Section 2.7.4 of Three-Way Contract]

43. Provider must be appropriately licensed or certified, as applicable, if required pursuant to federal and state requirements. [Section 2.7.3.4 of Three-Way Contract]

44. Provider shall notify MCO immediately if Provider has lost any required license or state or federal approval, or been excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. [Section 5.1.5.1 and 5.3.4 of Three-Way Contract]

45. Provider shall not engage in any practice with respect to any Beneficiary that constitutes unlawful discrimination under any state or federal law or regulation. [Section 2.3.1.2 of Three-Way Contract]

46. As requested by MCO, Provider shall submit disclosures in accordance with 42 C.F.R. § 455 Subpart B and 42 C.F.R. § 1002.3. [Section 5.1.6.1 of Three-Way Contract]

47. Providers shall offer hours of operation to Beneficiaries that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service (if the Provider serves only Medicaid beneficiaries). [Section 2.8.5.3 of Three-Way Contract]

48. Provider must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) as outlined in the Three-Way Contract, and must maintain capacity to deliver services in a manner that accommodates the needs of Beneficiaries. [Section 2.8.1.3 of Three-Way Contract]

49. Upon MCO's request, Providers must provide the following information: (a) its name, address, and telephone number; (b) its areas of special experience, skills, and training, including any expertise in treating persons with physical disabilities, chronic illness, HIV/AIDS, or persons with serious mental illness; persons who are homeless; persons who are deaf, hard-of-hearing, blind, and/or visually impaired; or persons with co-occurring disorders; (c) its office hours, including the name of any Provider site open after 5:00 p.m. (Eastern Time) on weekdays and/or open on weekends; (d) its cultural and linguistic capabilities, including languages spoken by the Provider or by any skilled medical interpreter at the Provider's site; (e) Provider licensing information; (f) whether it is accessible for people with physical disabilities; (g) whether it is accepting new patients; (h) whether it is accessible by public transportation; and (h) any languages other than English spoken by Provider or by skilled medical interpreters at Provider's site, and whether translation services are available. [Section 2.12.5.2 of Three-Way Contract]

50. As requested and required, Provider must provide any information that CMS and/or the Department require (a) under the Three-Way Contract related to the performance of MCO's responsibilities, including non-medical information for the purposes of research and evaluation; (b) to comply with all applicable federal or state laws and regulations; and (c) for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Beneficiary satisfaction, Beneficiary Grievances and Appeals, and enrollment/disenrollment rates. [Section 2.14.1.1 of Three-Way Contract]

51. Provider shall collaborate with MCO in the collection and maintenance of all Encounter Data for all Covered

Services that Provider provides to Beneficiaries, ensuring that all such data can be linked to the Department eligibility data. [Section 2.15 of Three-Way Contract]

52. In connection with the Demonstration, Provider shall act in an independent capacity and not as an officer or employee of the federal government or the Department. [Section 5.1.3.1 of Three-Way Contract]

53. Provider shall not have any interest that will conflict, as determined by CMS and the Department, with the performance of MCO's services under the Three-Way Contract, or that may be otherwise anticompetitive, including without limitation any financial, legal, contractual, or other business interest in any entity performing enrollment functions for the Department. [Section 5.3.17.1 of Three-Way Contract]

54. Provider shall conduct all activities in accordance with the Beneficiary rights and protections set forth under 42 C.F.R. § 438.100, 42 C.F.R. § 422 Subpart C, and Appendix B ("Beneficiary Rights") of the Three-Way Contract. [Appendix B of Three-Way Contract]

55. Provider may not reuse or provide other entities access to the CMS information system, or data obtained from the system or the State of Ohio, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the MCO contracted with CMS and the Department. [Appendix E of Three-Way Contract]

56. If the Provider is discharging an Beneficiary from a hospital, Provider must assure that the Beneficiary receives a written notice of explanation called an "Important Message from Medicare About your Rights" regarding the right to appeal the discharge decision from an inpatient hospital admission. [Section 2.10.4.1 of Three-Way Contract]

OHIO DUAL ELIGIBLE COMPLIANCE ADDENDUM – 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 Amendment 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. Required Provisions:

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)]

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: [42 C.F.R. §§ 422.504(i)(4) and (5)]

(i) The delegated activities and reporting responsibilities are specified as follows:

See delegated activities and reporting responsibilities set forth in the Radiology Management Services Agreement, Exhibit 1

(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.

(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.

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.

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

Exhibit B

Company Affiliates
Including all products listed in Exhibit A

Affiliate Name	Address	City	State	Zip
Aetna Better Health Inc. dba Aetna Better Health of Illinois	333 W Wacker Drive, Suite 2200	Chicago	Illinois	60606
Aetna Better Health, Inc. dba Aetna Better Health of Louisiana	2400 Veterans Memorial Blvd., Suite 200	Kenner	Louisiana	70062
Aetna Better Health of Michigan Inc.	1333 Gratiot Ave, Suite 400	Detroit	Michigan	48207
Aetna Better Health of Missouri LLC	10 South Broadway #1200	St. Louis	Missouri	63102
Aetna Better Health Inc. dba Aetna Better Health of Ohio	7400 West Campus Drive	New Albany	Ohio	43054
Aetna Better Health Inc. dba Aetna Better Health of Pennsylvania	2000 Market St., Suite 850	Philadelphia	Pennsylvania	19103
Aetna Health Inc. dba Aetna Better Health Kids	2000 Market St., Suite 850	Philadelphia	Pennsylvania	19103
Coventry Health and Life Insurance Company dba CoventryCares of Kentucky	9900 Corporate Campus Drive, Suite 1000	Louisville	Kentucky	40223
Coventry Health Care of Virginia, Inc. dba CoventryCares of Virginia	9881 Mayland Dr.	Richmond	Virginia	23233
Coventry Health Care of West Virginia, Inc. dba CoventryCares of West Virginia	500 Virginia Street E Suite 400	Charleston	West Virginia	25301

Exhibit E

CPT Codes List

®CPT Code	CPT® Description	Offering	Category
70450	CT Head without contrast	CT	AI
70460	CT Head with contrast	CT	AI
70470	CT Head with & without contrast	CT	AI
70480	CT Orbit, et al without contrast	CT	AI
70481	CT Orbit, et al with contrast	CT	AI
70482	CT Orbit, et al W & W/O	CT	AI
70486	CT Maxillofacial area, (sinus) without contrast	CT	AI
70487	CT Maxillofacial area, (sinus) with contrast	CT	AI
70488	CT Maxillofacial area, (sinus) W & W/O	CT	AI
70490	CT Soft-tissue Neck without contrast	CT	AI
70491	CT Soft-tissue Neck with contrast	CT	AI
70492	CT Soft-tissue Neck with & without contrast W & W/O	CT	AI
71250	CT Chest without contrast	CT	AI
71260	CT Chest with contrast	CT	AI
71270	CT Chest with and without contrast W & W/O	CT	AI
72125	CT Cervical Spine without contrast	CT	AI
72126	CT Cervical Spine with contrast	CT	AI
72127	CT Cervical Spine with and with out contrast W & W/O	CT	AI
72128	CT Thoracic Spine without contrast	CT	AI
72129	CT Thoracic Spine with contrast	CT	AI
72130	CT Thoracic Spine with and without contrast W & W/O	CT	AI
72131	CT Lumbar Spine without contrast	CT	AI
72132	CT Lumbar Spine with contrast	CT	AI
72133	CT Lumbar Spine with and without out contrast W & W/O	CT	AI
74150	CT Abdomen without contrast	CT	AI
74160	CT Abdomen with contrast	CT	AI
74170	CT Abdomen with and without contrast W & W/O	CT	AI
72192	CT Pelvis without contrast	CT	AI
72193	CT Pelvis with contrast	CT	AI
72194	CT Pelvis with and without contrast W & W/O	CT	AI
74176	CT Abdomen & Pelvis, without contrast	CT	AI

74177	CT Abdomen & Pelvis, with contrast	CT	AI
74178	CT Abdomen & Pelvis, with and without contrast	CT	AI
73200	CT Upper Extremity without contrast	CT	AI
73201	CT Upper Extremity with contrast	CT	AI
73202	CT Upper Extremity with and without contrast W & W/O	CT	AI
73700	CT Lower Extremity without contrast	CT	AI
73701	CT Lower Extremity with contrast	CT	AI
73702	CT Lower Extremity with and without contrast W & W/O	CT	AI
76380	CT Limited or Localized follow-up	CT	AI
70496	CTA HEAD, with contrast, including noncontrast images, if performed, & image post-processing	CT	AI
70498	CTA NECK, with contrast, including noncontrast images, if performed, & image post-processing	CT	AI
71275	CTA CHEST, (non-coronary), with contrast, including noncontrast images, if performed, & image post-processing	CT	AI
72191	CTA PELVIS, with contrast, including noncontrast images, if performed, & image post-processing	CT	AI
73206	CTA Upper Extremity, with contrast, including noncontrast images, if performed, & image postprocessing	CT	AI
73706	CTA Lower Extremity, with contrast, including noncontrast images, if performed, & image postprocessing	CT	AI
74174	Computed tomographic angiography; abdomen and pelvis; with contrast material(s), including non contrast inmages, if performed, and image postprocessing	CT	AI
74175	CTA ABDOMEN, with contrast, including noncontrast images, if performed, & image postprocessing	CT	AI
75635	CTA ABDOMINAL AORTA and bilateral iliofemoral lower extremity runoff, with contrast, including noncontrast images, if performed, and image post-processing	CT	AI
77011	CT Guidance for stereotactic localization	CT	AI
77012	CT Guidance for needle placement (eg, biopsy, aspiration, injection), radiological supervision and interpretation	CT	AI
77013	CT Guidance for, and monitoring of, parenchymal tissue ablation	CT	AI
77078	CT BONE MINERAL DENSITY study, 1 or more sites, axial skeleton	CT	AI
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing;	CT	AI

	without contrast material		
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	CT	AI
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	CT	AI
0042T	Cerebral Perfusion Analysis using CT with contrast	CT	AI
76497	Unlisted CT procedure (eg, diagnostic, interventional)	CT	AI
75572	CT, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image post processing, assessment of cardiac function, and evaluation of venous structures, if performed)	CT	AI
75573	CT, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image post processing, assessment of cardiac LV function, RV structure and function and evaluation of venous structures, if performed)	CT	AI
75571	CT, heart, without contrast with quantitative evaluation of coronary calcium	CT	AI
S8092	CT ELECTRON BEAM (Ultrafast CT) for calcium scoring	CT	AI
75574	CT, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	CT	AI
70540	MRI Orbit, Face and/or Neck without contrast	MR	AI
70542	MRI Orbit, Face and/or Neck with contrast	MR	AI
70543	MRI Orbit, Face and/or Neck W & W/O	MR	AI
70551	MRI Brain (Head) without contrast	MR	AI
70552	MRI Brain (Head) with contrast	MR	AI
70553	MRI Brain (Head) with and without contrast W & W/O	MR	AI
71550	MRI Chest without contrast	MR	AI
71551	MRI Chest with contrast	MR	AI
71552	MRI Chest with and without contrast W & W/O	MR	AI
72141	MRI Cervical Spine without contrast	MR	AI
72142	MRI Cervical Spine with contrast	MR	AI
72156	MRI Cervical Spine with and without contrast	MR	AI

	W & W/O		
72146	MRI Thoracic Spine without contrast	MR	AI
72147	MRI Thoracic Spine with contrast	MR	AI
72157	MRI Thoracic Spine with and without contrast W & W/O	MR	AI
72148	MRI Lumbar Spine without contrast	MR	AI
72149	MRI Lumbar Spine with contrast	MR	AI
72158	MRI Lumbar Spine with and without contrast W & W/O	MR	AI
72195	MRI Pelvis without contrast	MR	AI
72196	MRI Pelvis with contrast	MR	AI
72197	MRI Pelvis with and without contrast W & W/O	MR	AI
73218	MRI Upper Extremity-other than joint-without contrast	MR	AI
73219	MRI Upper Extremity-other than joint-with contrast	MR	AI
73220	MRI Upper Extremity-other than joint-W & W/O	MR	AI
73221	MRI Any Joint of Upper Extremity--without contrast	MR	AI
73222	MRI Any Joint of Upper Extremity--with contrast	MR	AI
73223	MRI Any Joint of Upper Extremity—W & W/O	MR	AI
73718	MRI Lower Extremity-other than joint-without contrast	MR	AI
73719	MRI Lower Extremity-other than joint-with contrast	MR	AI
73720	MRI Lower Extremity-other than joint- W & W/O	MR	AI
73721	MRI Any Joint of Lower Extremity--without contrast	MR	AI
73722	MRI Any Joint of Lower Extremity--with contrast	MR	AI
73723	MRI Any Joint of Lower Extremity—W & W/O	MR	AI
74181	MRI Abdomen without contrast	MR	AI
74182	MRI Abdomen with contrast	MR	AI
74183	MRI Abdomen with and without contrast W & W/O	MR	AI
70554	MRI Brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	MR	AI
70555	MRI, Brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	MR	AI
70336	MRI Temporomandibular Joint (s)	MR	AI

77084	MRI Bone Marrow blood supply	MR	AI
77058	MRI BREAST, without and/or with contrast UNILATERAL	MR	AI
77059	MRI BREAST, without and/or with contrast BILATERAL	MR	AI
0159T	CAD, including computer algorithm analysis, BREAST MRI	MR	AI
70544	MR Angiography (MRA) Head without contrast	MR	AI
70545	MR Angiography (MRA) Head with contrast	MR	AI
70546	MR Angiography (MRA) Head with and without contrast W & W/O	MR	AI
70547	MR Angiography (MRA) Neck without contrast	MR	AI
70548	MR Angiography (MRA) Neck with contrast	MR	AI
70549	MR Angiography (MRA) Neck with and without contrast W & W/O	MR	AI
71555	MR Angiography (MRA) Chest (excluding myocardium)- W or W/O	MR	AI
72159	MR Angiography (MRA) Spinal Canal and contents -with or w/o contrast	MR	AI
72198	MR Angiography (MRA) Pelvis -with or without contrast	MR	AI
73225	MR Angiography (MRA) Upper Extremity - with or without contrast	MR	AI
73725	MR Angiography (MRA) Lower Extremity- with or without contrast	MR	AI
74185	MR Angiography (MRA) Abdomen-with or without contrast	MR	AI
77021		MR	AI
77022	MR guidance for, and monitoring of, parenchymal tissue ablation (usually used in conjunction with surgery, non-MSI test for most Clients)	MR	AI
S8037	MRCP (Magnetic Resonance Cholangiopancreatography)	MR	AI
76390	MR Spectroscopy (MRS)	MR	AI
S8042	MRI Low Field	MR	AI
S8035	Magnetic Source Imaging	MR	AI
76498	Unlisted MR procedure (eg, diagnostic, interventional)	MR	AI
75557	Cardiac MRI for morphology and function without contrast	MR	AI
75559	Cardiac MRI for morphology and function without contrast material; with stress imaging	MR	AI
75561	Cardiac MRI for morphology and function without contrast, followed by contrast W & W/O	MR	AI
75563	Cardiac MRI for morphology and function without contrast, followed by contrast; with	MR	AI

	stress imaging		
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)	MR	AI
78608	PET Brain – metabolic evaluation	PET	AI
78609	PET Brain – perfusion evaluation	PET	AI
78811	PET imaging; limited area (eg, chest, head/neck)	PET	AI
78812	PET imaging; skull base to mid-thigh	PET	AI
78813	PET imaging; whole body	PET	AI
78814	PET imaging with concurrently acquired CT for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)	PET	AI
78815	PET imaging with concurrently acquired CT for attenuation correction and anatomical localization; skull base to mid-thigh	PET	AI
78816	PET imaging with concurrently acquired CT for attenuation correction and anatomical localization; whole body	PET	AI
78459	PET Cardiac (myocardial imaging) – metabolic evaluation	PET	AI
78491	PET Cardiac (myocardial imaging), perfusion single study at rest or stress	PET	AI
78492	PET Cardiac (myocardial imaging), perfusion multiple studies rest/stress	PET	AI
76376	3D Rendering with interpretation and reporting of CT, MRI, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation	3D	AI
76377	3D Rendering with interpretation and reporting of CT, MRI, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation	3D	AI
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation	U/S	US OB
76802	. . . each additional gestation (List separately in addition to code for primary procedure)	U/S	US OB
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation	U/S	US OB
76810	. . . each additional gestation (List separately in addition to code for primary procedure)	U/S	US OB
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal	U/S	US OB

	evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation		
76812	. . . each additional gestation (List separately in addition to code for primary procedure)	U/S	US OB
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	U/S	US OB
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation	U/S	US OB
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses	U/S	US OB
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus	U/S	US OB
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	U/S	US OB
76818	Fetal biophysical profile; with non-stress testing	U/S	US OB
76819	Fetal biophysical profile; without non-stress testing	U/S	US OB
76820	Doppler velocimetry, fetal; umbilical artery	U/S	US OB
76821	Doppler velocimetry, fetal; middle cerebral artery	U/S	US OB
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;	U/S	US OB
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study	U/S	US OB
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete	U/S	US OB
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study	U/S	US OB
76506	Echoencephalography, real time with image documentation (gray scale)	U/S	US
76536	Ultrasound, soft tissues of head and neck	U/S	US

	(eg, thyroid, parathyroid, parotid), B-scan and/or real time with image documentation		
76604	Ultrasound, chest, (includes mediastinum) real time with image documentation	U/S	US
76700	Ultrasound, abdominal, B-scan and/or real time with image documentation; complete	U/S	US
76705	Ultrasound, abdominal, B-scan and/or real time with image documentation; limited	U/S	US
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete	U/S	US
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; limited	U/S	US
76776	Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation	U/S	US
76800	Ultrasound, spinal canal and contents	U/S	US
76830	Ultrasound, transvaginal	U/S	US
76856	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation, complete	U/S	US
76857	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation, limited or follow-up	U/S	US
76870	Ultrasound, scrotum and contents	U/S	US
76872	Ultrasound, transrectal	U/S	US
76881	Ultrasound, extremity, non-vascular, real time with image documentation: complete	U/S	US
76882	Ultrasound, extremity, non-vascular, real time with image documentation: limited, anatomic specific	U/S	US
76885	Ultrasound, infant hips, real time with image documentation; dynamic (requiring physician manipulation)	U/S	US
76886	Ultrasound, infant hips, real time with image documentation; limited, static (not requiring physician manipulation)	U/S	US
G0389	Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening	U/S	US
93998	Unlisted noninvasive vascular diagmostic study	U/S	US
93880	Duplex scan of extracranial arteries; complete bilateral study	U/S	US
93882	Duplex scan of extracranial arteries; unilateral or limited study	U/S	US
93886	Transcranial Doppler study of the intracranial arteries; complete study	U/S	US
93888	Transcranial Doppler study of the intracranial arteries; limited study	U/S	US
93890	Transcranial Doppler study of the	U/S	US

	Intracranial arteries; vasoreactive study		
93892	Transcranial Doppler study of the intracranial arteries; emboli detection W/O intravenous microbubble injection	U/S	US
93893	Transcranial Doppler study of the intracranial arteries; emboli detection with intravenous microbubble injection	U/S	US
93922	Limited bilateral noninvasive physiologic studies of upper or lower arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with transcutaneous oxygen tension measurements at 1-2 levels)	U/S	US
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels	U/S	US
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography	U/S	US
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	U/S	US
93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study	U/S	US
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study	U/S	US
93931	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study	U/S	US
93965	Non-invasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)	U/S	US
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	U/S	US
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	U/S	US

93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	U/S	US
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	U/S	US
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study	U/S	US
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; limited study	U/S	US
93980	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study	U/S	US
93981	Duplex scan of arterial inflow and venous outflow of penile vessels; limited study	U/S	US
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	U/S	US
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed	U/S	US
76970	Ultrasound study follow-up (specify)	U/S	US
76999	Unlisted ultrasound procedure (e.g., diagnostic, interventional)	U/S	US
22520	PERCUTANEOUS VERTEBROPLASTY THORACIC	Spinal Injections	Pain Mgmt
22521	PERCUTANEOUS VERTEBROPLASTY LUMBAR	Spinal Injections	Pain Mgmt
22522	PERCUT VERTEBROPLASTY ADDL	Spinal Injections	Pain Mgmt
20552	INJECTION SINGLE/MLT TRIGGER POINT 1/2 MUSCLES	Other Injections	Pain Mgmt
20553	INJECTION SINGLE/MLT TRIGGER POINT 3/> MUSCLES	Other Injections	Pain Mgmt
22523	PERCUTANEOUS VERTEBRAL AUGMENTATION THORACIC	Spinal Injections	Pain Mgmt
22524	PERCUTANEOUS VERTEBRAL AUGMENTATION LUMBAR	Spinal Injections	Pain Mgmt
22525	PERQ VERTEBRAL AUGMENTATION EA ADDL THRC/LMBR	Spinal Injections	Pain Mgmt
22526	PERQ INTRDSCL ELECTROTHRM ANNULOPLASTY 1 LVL	Spinal Injections	Pain Mgmt
22527	PERQ INTRDSCL ELECTROTHRM ANNULOPLASTY ADDL LVL	Spinal Injections	Pain Mgmt
27096	INJECTION SI JOINT ARTHROGRAPHY&/ANES/STEROID	Spinal Injections	Pain Mgmt
62263	PRQ LSS EDRL ADS SLN NJX/MCHNL LOCLZJ 2+ D	Spinal Injections	Pain Mgmt
62264	PRQ LSS EDRL ADS SLN NJX/MCHNL LOCLZJ 1 D	Spinal Injections	Pain Mgmt
62280	NJX/NFS NULYT SBST SBST SARACH	Spinal Injections	Pain Mgmt
62281	NJX/NFS NULYT SBST EDRL CRV/THRC	Spinal Injections	Pain Mgmt
62282	NJX/NFS NULYT SBST EDRL LMBR SAC	Spinal Injections	Pain Mgmt

62287	DCMPRN PERQ NUCLEUS PULPOSUS 1/> LEVELS LUMBAR	Spinal Injections	Pain Mgmt
62290	NJX DISKOGRAPY EA LVL LMBR	Spinal Injections	Pain Mgmt
62291	NJX DISKOGRAPY EA LVL CRV/THRC	Spinal Injections	Pain Mgmt
62292	NJX CHEMONUCLEOLSS DISKOGRAPY 1+ LMBR	Spinal Injections	Pain Mgmt
62310	NJX C+-DX/THER SBST EDRL/SARACH CRV/THRC	Spinal Injections	Pain Mgmt
62311	NJX C+-DX/THER SBST EDRL/SARACH LMBR SAC	Spinal Injections	Pain Mgmt
62318	NJX NFS/BOLUS DX/SBST EDRL/SARACH CRV/THRC	Spinal Implants	Pain Mgmt
62319	NJX NFS/BOLUS DX/SBST EDRL/SARACH LMBR SAC	Spinal Implants	Pain Mgmt
62350	IMPLTJ REVJ/RPSG ITHCL/EDRL CATH PMP W/O LAM	Spinal Implants	Pain Mgmt
62351	IMPLTJ REVJ/RPSG ITHCL/EDRL CATH W/LAM	Spinal Implants	Pain Mgmt
62355	RMVL PREVIOUSLY IMPLTED ITHCL/EDRL CATH	Spinal Implants	Pain Mgmt
62360	IMPLTJ/RPLCMT ITHCL/EDRL DRUG NFS SUBQ RSVR	Spinal Implants	Pain Mgmt
62361	IMPLTJ/RPLCMT ITHCL/EDRL NFS NON-PRGRBL PMP	Spinal Implants	Pain Mgmt
62362	IMPLTJ/RPLCMT ITHCL/EDRL DRUG NFS PRGRBL PMP	Spinal Implants	Pain Mgmt
62365	RMVL SUBQ RSVR/PMP	Spinal Implants	Pain Mgmt
62367	ELEC ALYS PRGRBL PMP W/O REPRGRMG	Spinal Implants	Pain Mgmt
62368	ELEC ALYS PRGRBL PMP REPRGRMG	Spinal Implants	Pain Mgmt
62370	ANL SP INF PMP W/MDREPRG&FIL	Spinal Implants	Pain Mgmt
63650	PRQ IMPLTJ NSTIM ELTRD RA EDRL	Spinal Implants	Pain Mgmt
63655	LAM IMPLTJ NSTIM ELTRDS PLATE/PADDLE EDRL	Spinal Implants	Pain Mgmt
63661	RMVL SPINAL NSTIM ELTRD PRQ ARRAY INCL FLUOR	Spinal Implants	Pain Mgmt
63662	RMVL SPINAL NSTIM ELTRD PLATE/PADDLE INCL FLUOR	Spinal Implants	Pain Mgmt
63663	REVJ INCL RPLCMT NSTIM ELTRD PRQ RA INCL FLUOR	Spinal Implants	Pain Mgmt
63664	REVJ INCL RPLCMT NSTIM ELTRD PLT/PDLE INCL FLUOR	Spinal Implants	Pain Mgmt
63685	INSJ/RPLCMT SPI NPGR DIR/INDUXIVE COUPLING	Spinal Implants	Pain Mgmt
63688	REVJ/RMVL IMPLTED SPI NPGR	Spinal Implants	Pain Mgmt
64405	NJX ANES GRTER OCCIPITAL NRV	Peripheral Nerve Procedures	Pain Mgmt
64479	NJX ANES&/STRD TFRML EDRL CRV/THRC 1 LVL	Spinal Injections	Pain Mgmt
64480	NJX ANES&/STRD TFRML EDRL CRV/THRC EA LVL	Spinal Injections	Pain Mgmt
64483	NJX ANES&/STRD TFRML EDRL LMBR/SAC 1 LVL	Spinal Injections	Pain Mgmt
64484	NJX ANES&/STRD TFRML EDRL LMBR/SAC EA LVL	Spinal Injections	Pain Mgmt
64490	NJX DX/THER AGT PVRT FACET JT CRV/THRC 1 LEVEL	Spinal Injections	Pain Mgmt

64491	NJX DX/THER AGT PVRT FACET JT CRV/THRC 2ND LEVEL	Spinal Injections	Pain Mgmt
64492	NJX DX/THER AGT PVRT FACET JT CRV/THRC 3+ LEVEL	Spinal Injections	Pain Mgmt
64493	NJX DX/THER AGT PVRT FACET JT LMBR/SAC 1 LEVEL	Spinal Injections	Pain Mgmt
64494	NJX DX/THER AGT PVRT FACET JT LMBR/SAC 2ND LEVEL	Spinal Injections	Pain Mgmt
64495	NJX DX/THER AGT PVRT FACET JT LMBR/SAC 3+ LEVEL	Spinal Injections	Pain Mgmt
64510	NJX ANES STELLATE GANGLION CRV SYMPATHETIC	Spinal Injections	Pain Mgmt
64520	NJX ANES LMBR/THRC PVRT SYMPATHETIC	Spinal Injections	Pain Mgmt
64581	INC IMPLTJ NSTIM ELTRDS SAC NRV	Peripheral Nerve Procedures	Pain Mgmt
64633	DSTR NROLYTC AGNT PARVERTEB FCT SNGL CRVCL/THORA	Spinal Injections	Pain Mgmt
64634	DSTR NROLYTC AGNT PARVERTEB FCT ADDL CRVCL/THORA	Spinal Injections	Pain Mgmt
64635	DSTR NROLYTC AGNT PARVERTEB FCT SNGL LMBR/SACRAL	Spinal Injections	Pain Mgmt
64636	DSTR NROLYTC AGNT PARVERTEB FCT ADDL LMBR/SACRAL	Spinal Injections	Pain Mgmt
64640	DSTRJ NULYT OTH PRPH NRV/BRANCH	Peripheral Nerve Procedures	Pain Mgmt
72275	EPIDUROGRAPY RS&I	Spinal Injections	Pain Mgmt
72285	DISKOGRAPY CRV/THRC RS&I	Spinal Injections	Pain Mgmt
72291	RAD S&I PERQ VRTPLS/SACRPLSTY PR VRT BODY FLUOR	Spinal Injections	Pain Mgmt
72292	RAD S&I PERQ VRTPLS/SACRPLSTY PER VRT BODY CT	Spinal Injections	Pain Mgmt
72295	DISKOGRAPY LMBR RS&I	Spinal Injections	Pain Mgmt
95971	ELEC ALYS NSTIM PLS GEN SMPL SC/PERPH W/PRGRMG	Spinal Implants	Pain Mgmt
95972	ELEC ALYS NSTIM PLS GEN CPLX SC/PERPH 1ST HR	Spinal Implants	Pain Mgmt
95973	ELEC ALYS NSTIM PLS GEN CPLX SC/PERPH EA 30 MIN	Spinal Implants	Pain Mgmt
95991	SPIN/BRAIN PUMP REFIL & MAIN	Spinal Implants	Pain Mgmt
0200T	PERQ SACRAL AUGMENT UNI +-BALLOON/DEVICE 1+NDL	Spinal Injections	Pain Mgmt
0201T	PERQ SACRAL AUGMENTATION BI +-BALO/DEVICE 2+NDL	Spinal Injections	Pain Mgmt
0213T	INJECT PARAVERT FACET JT/NERVE CERV/THORAC 1LVL	Spinal Injections	Pain Mgmt
0214T	INJECT PARAVER FACET JT/NERVE CERV/THORAC LVL 2	Spinal Injections	Pain Mgmt
0215T	INJECT PARAVER FACET JT/NERVE CERV/THORAC 3+LVL	Spinal Injections	Pain Mgmt

0216T	INJECTION PARAVERT FACET JT/NERVE LMBR/SAC 1LVL	Spinal Injections	Pain Mgmt
0217T	INJECTION PARAVERT FACET JT/NERVE LMBR/SAC LVL2	Spinal Injections	Pain Mgmt
0218T	INJECTION PARAVER FACET JT/NERVE LMBR/SAC 3+LVL	Spinal Injections	Pain Mgmt
0228T	INJ ANES AGT&/STRD TFRML EDRL US CRV/THRC 1LVL	Spinal Injections	Pain Mgmt
0229T	INJ ANES AGT&/STRD TFRML EDRL US CRV/THRC + LVL	Spinal Injections	Pain Mgmt
0230T	INJ ANES AGT&/STRD TFRML EDRL US LMBR/SAC 1LVL	Spinal Injections	Pain Mgmt
0231T	INJ ANES AGT&/STRD TFRML EDRL US LMBR/SAC + LVL	Spinal Injections	Pain Mgmt
C1767	GENERATOR NEUROSTIMULATOR NONRECHARGEABLE	Spinal Implants	Pain Mgmt
C1778	LEAD NEUROSTIMULATOR	Spinal Implants	Pain Mgmt
C1787	PATIENT PROGPATIENT PROGRAMMER NEUROSTIMULATOR	Spinal Implants	Pain Mgmt
C1816	RECEIVER AND/OR TRANSMITTER NEUROSTIMULATOR	Spinal Implants	Pain Mgmt
C1820	GENERATOR NEUROSTIM W/RECHARG BATT & CHRGING SYS	Spinal Implants	Pain Mgmt
C1883	ADAPTOR/EXT PACING LEAD/NEUROSTIMULATOR LEAD	Spinal Implants	Pain Mgmt
C1897	LEAD NEUROSTIMULATOR TEST KIT	Spinal Implants	Pain Mgmt
G0260	INJ PROC SI JNT;ANES STEROID&/TX AGT&ARTHROGRPH	Spinal Injections	Pain Mgmt
L8680	IMPLANTABLE NEUROSTIMULATOR ELECTRODE EACH	Spinal Implants	Pain Mgmt
L8681	PT PROG W/IMPL PROG NEUROSTM PULSE GEN REPL ONLY	Spinal Implants	Pain Mgmt
L8682	IMPLANTABLE NEUROSTIMULATOR RADIOFREQ RECEIVER	Spinal Implants	Pain Mgmt
L8683	RF TRNSMT USE W/IMPLANTABLE NEUROSTIM RF RECV	Spinal Implants	Pain Mgmt
L8685	IMPLANT NEUROSTIM 1 ARRAY RECHARGEABLE	Spinal Implants	Pain Mgmt
L8686	IMPLANT NEUROSTIM 1 ARRAY NON-RECHARGEABLE	Spinal Implants	Pain Mgmt
L8687	IMPLANT NEUROSTIM 2 ARRAY RECHARGEABLE	Spinal Implants	Pain Mgmt
L8688	IMPLANT NEUROSTIM 2 ARRAY NON-RECHARGEABLE	Spinal Implants	Pain Mgmt
L8689	EXT RECHARG SYS BATTRY IMPL NEUROSTIM REPL ONLY	Spinal Implants	Pain Mgmt
S2360	PERQ VERTPLSTY 1 VERT BDY UNILAT/BILAT INJ; CERV	Spinal Injections	Pain Mgmt
S2361	EACH ADDITIONAL CERVICAL VERTEBRAL BODY	Spinal Injections	Pain Mgmt

SEVENTH AMENDMENT TO THE RADIOLOGY MANAGEMENT SERVICES AGREEMENT

This Amendment ("Amendment") is dated December 15, 2015, and is between **Aetna Medicaid Administrators LLC**, on behalf of itself and its Affiliates ("Company"), and **MedSolutions, Inc.**, d/b/a eviCore healthcare, a Tennessee corporation with its principal place of business in Franklin, TN ("Delegated Entity").

WHEREAS, Company and Delegated Entity entered into a Radiology Management Services Agreement dated January 1, 2014 ("Agreement") for the provision of Utilization Management services;

WHEREAS, Company and Delegated Entity have since amended the Agreement on or around the following dates: First Amendment on April 1, 2014 (Musculoskeletal Pain Management); Second Amendment on April 1, 2014 (adding Maryland and Pennsylvania Regulatory Addenda); Third Amendment was never executed and is intentionally omitted; Fourth Amendment on July 16, 2014 (adding Missouri and Michigan); Fifth Amendment originally executed on May 1, 2015 and re-executed on October 19, 2015 (adding Louisiana); Sixth Amendment on May 1, 2015 (revising Musculoskeletal Pain Management Rates and adding Ohio Regulatory Addendum); and

WHEREAS, Company and Delegated Entity desire to amend the Agreement with respect to Aetna Better Health of Michigan Inc. ("ABH-Michigan"), to update the Louisiana Medicaid/CHIP Compliance Addendum, and to include Aetna Better Health of Kentucky Insurance Company ("ABH-Kentucky") and Coventry Health Care of Virginia, Inc. dba CoventryCares of Virginia, and update the Compensation Schedule and Company Affiliates Exhibit.

NOW, THEREFORE, in consideration of the mutual covenants and promises stated herein and other good and valuable consideration, and intending to be legally bound, Company and Delegated Entity agree as follows:

1. The Agreement's Exhibit 2: Compensation Schedule is hereby deleted in its entirety and replaced with the attached **Exhibit 2: Compensation Schedule.**

2. The Agreement's Individual Sites Regulatory Compliance Addendum (Exhibit A) is hereby amended to: (a) delete in their entirety the "Medicaid Addendum – Exhibit A Michigan" and the associated Michigan "Product Participation Schedule" and (b) incorporate into the Agreement the following Exhibits that are attached to this Amendment:

    a. Exhibit A.1—Individual Sites Regulatory Compliance Addendum (ABH-Michigan) **Program Participation Schedule;**

    b. Exhibit A.2—Individual Sites Regulatory Compliance Addendum (ABH-Michigan) **Governing Medicaid and CHIP Services**; and

    c. Exhibit A.3—Individual Sites Regulatory Compliance Addendum (ABH-Michigan) **Governing Medicare-Medicaid Dual-Eligible Services.**

2.1 ABH-Michigan's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services that Delegated Entity provides with respect to Members who are eligible and covered under the ABH-Michigan Plans set forth in Exhibit A.1 (Program Participation Schedule).

2.2 For the avoidance of any doubt, with respect to the provision of Covered Services to Members who are eligible and covered under the Medicare-Medicaid Plans set forth in Exhibit A.1 (Program Participation Schedule), Exhibit A.3 hereto shall supersede and replace the following document that is attached to the Agreement: Exhibit D (Addendum for Medicare-Medicaid Dual Eligible Members).

2.3 Company represents and warrants that ABH-Michigan has duly authorized Company to enter into this Amendment on ABH-Michigan's behalf, and to bind ABH-Michigan to the terms and provisions of the Agreement, as modified herein and by the attached Exhibits A.1 through A.3.

3. The Agreement's Individual Sites Regulatory Compliance Addendum (Exhibit A) is hereby amended to add ABH-Kentucky to the Agreement effective **February 1, 2016** and to incorporate into the Agreement the following Exhibits that are attached to this Amendment:

   a. Exhibit A.4—Individual Sites Regulatory Compliance Addendum (Kentucky) **Program Participation Schedule;**

   b. Exhibit A.5—Individual Sites Regulatory Compliance Addendum (Kentucky) **Governing Kentucky Medicaid Services.**

   3.1 ABH-Kentucky's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services that Delegated Entity provides to Members who are eligible and covered under the Plans set forth in Exhibit A.4 (Program Participation Schedule).

   3.2 Both Parties agree that the Agreement and Kentucky Regulatory Compliance Addendum are subject to regulatory review and may require changes prior to obtaining approval. The February 1, 2016 Kentucky effective date for the Agreement is expressly contingent upon Company obtaining any necessary regulatory approval.

   3.3 Both Parties agree a full risk arrangement may be beneficial and will negotiate in good faith after the migration of the Kentucky Plan.

   3.4

4. The Agreement's Individual Sites Regulatory Compliance Addendum (Exhibit A) is hereby amended (a) to delete in their entirety the "Louisiana Medicaid/CHIP Compliance Addendum" and the associated Louisiana "Product Participation Schedule" and incorporate into the Agreement the following Exhibits that are attached to this Amendment:

   a. Exhibit A.6—Individual Sites Regulatory Compliance Addendum (Louisiana) **Program Participation Schedule;**

   b. Exhibit A.7—Individual Sites Regulatory Compliance Addendum **Louisiana Medicaid/CHIP Compliance Addendum.**

5. The Agreement's Individual Sites Regulatory Compliance Addendum (Exhibit A) is hereby amended to add Coventry Health Care of Virginia, Inc. dba CoventryCares of Virginia to the Agreement and to incorporate into the Agreement the following Exhibits, which shall be effective on **April 1, 2016** and upon the receipt of all applicable state and regulatory approvals.

   a. Exhibit A.8—Individual Sites Regulatory Compliance Addendum (Virginia) **Program Participation Schedule;**

   b. Exhibit A.9—Individual Sites Regulatory Compliance Addendum **Virginia Medicaid Compliance Addendum - Subcontractor.**

6. Delegated Entity shall comply with the terms of each of the attached Individual Sites Regulatory Compliance Addenda to the extent applicable to the Agreement. In the event of any conflict between the terms of the attached Individual Sites Regulatory Compliance Addenda, and any of the other terms of the Agreement, including any other attachments, schedules, exhibits, and/or addenda made part of the Agreement, the terms of the Individual Sites Regulatory Compliance Addenda shall govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the respective Plans as identified in applicable Program Participation Schedule.

7. The Agreement's Exhibit B Company Affiliates is hereby deleted in its entirety and replaced with the attached **Exhibit B Company Affiliates.**

8. Capitalized terms not otherwise defined herein shall have the meaning ascribed to them in the Agreement.

9. All other terms and provisions of the Agreement not amended herein shall remain in full force and effect, without modification.

10. The Parties ratify and affirm the Agreement, and agree that it is in full force and effect as amended herein. In the event of any inconsistency between the terms of this Amendment and the Agreement, the terms of this Amendment shall govern and control.

IN WITNESS WHEREOF, the Parties have caused this Amendment to be signed by their duly authorized officers as of the date indicated in the introductory clause.

MEDSOLUTIONS, INC.

Signature

David J. Smith

Printed Name

EVP + President Radiology

Title

12/30/15

Date

Tax I.D. #: 62-1615395

NPI #: 1992077762

Medicaid #: N/A

Medicare #: N/A

AETNA MEDICAID ADMINISTRATORS LLC

Signature

DWAYNE SANSONE

Printed Name

VP, OPERATIONS

Title

12/30/15

Date

Exhibit 2: Compensation Schedule

The Administrative Fees by Member type and modality are listed in the following tables by state.

		[redacted]
Arizona	Advanced Imaging	
	Pain Management	
Illinois	Advanced Imaging	
	Pain Management	
Louisiana (effective 10.19.15)	Advanced Imaging	
	Pain Management	
Maryland	Advanced Imaging	
	Ultrasound – Non OB	
Missouri	Advanced Imaging	
	Ultrasound - OB Only	
Michigan	Advanced Imaging	
Ohio	Advanced Imaging	
	Ultrasound – Non OB	
	Pain Management	
Pennsylvania	Advanced Imaging	
	Ultrasound – Non OB	
	Pain Management	
Texas	Advanced Imaging	

- Advanced Imaging includes management of MRI, MRA, CT, CTA and PET
- Cardiology includes management of Nuclear Cardiology, Heart Catheterization, Stress Echo, TTE, and TEE
- Ultrasound includes management of OB and non-OB ultrasound, if the plan's TANF ultrasound utilization is below [redacted]

KENTUCKY AND VIRGINIA HIGH TOUCH ASO PRODUCT

Enhanced Clinical Quality Review

With regard to Kentucky and Virginia, Company and Delegated Entity agree to pursue and implement an enhanced clinical quality review for Advanced Imaging ("Clinical Quality Review Services") for certain Members. The Administrative Fees by Member type and modality are listed in the following table by state:

State	Modality	TANF	CHIP	ABD	Medicaid Expansion <=18	Medicaid Expansion Adult
Kentucky (effective 2/01/2016)	Advanced Imaging	[redacted]				
	Ultrasound					
	Ultrasound – OB					
	Ultrasound – Non OB					
	Pain Management					
Virginia (effective 4/01/2016)	Advanced Imaging					
	Cardiology					
	Ultrasound OB only					
	Ultrasound Non-OB					
	Pain Management					

The Clinical Quality Review Services include enhanced review of Advanced Imaging Prior Authorization requests as follows:

1. Medical Necessity certifications, including alternative recommendations where appropriate, in accordance with evidenced based guidelines and Company's Clinical Policy Bulletin (CPB).
2. At least [redacted] (or as adjusted based on changes in clinical review effectiveness to achieve enhanced compliance with evidence based guidelines, as agreed to by the Parties) of precertification requests shall be subject to Nurse and/or Medical Director review to include determinations for compliance with evidenced based guidelines.

Each month, Delegated Entity shall charge Company an Administrative Fee for the provision of Delegated Entity Program Services. The monthly Administrative Fee shall be equal to the aggregate of the applicable per Member per month amounts set forth in the table below:

1. **Payment.** On or before the 15th day of each month, Company shall prepay Delegated Entity an Administrative Fee for the provision of Delegated Entity Program services.

a) If a Member is added to Company Membership on or before the 15th day of a month, a full month's Administrative Fee will be due for that month. There will be no Administrative Fee due for Member added after the 15th day of the month.

b) A full month's Administrative Fee will be due for the month of termination of a Member if the Member terminates after the 15th day of the month. If a Member terminates on or before the 15th day of a month, no Administrative Fee will be due for the month of termination.

2. **Adjustments.** Where Company, due to information delays, must make a retroactive addition or deletion to Delegated Entity's membership records, a retroactive adjustment shall be made concurrent therewith and such retroactive Administrative Fee adjustments shall not exceed sixty (60) days for each single Member. With the exception of any fraud investigation, the limit to the period of time in which Delegated Entity or Company can make a claim of an overpayment or underpayment or contest an underpayment or overpayment under this Agreement is one hundred eighty (180) days from the date the payment was made or one hundred eighty (180) days from the date of final adjudication.

The Administrative Payment. Amounts otherwise due to Delegated Entity shall be reduced as follows for Delegated Entity's failure to meet the Performance Guarantees set forth in Exhibit 3.

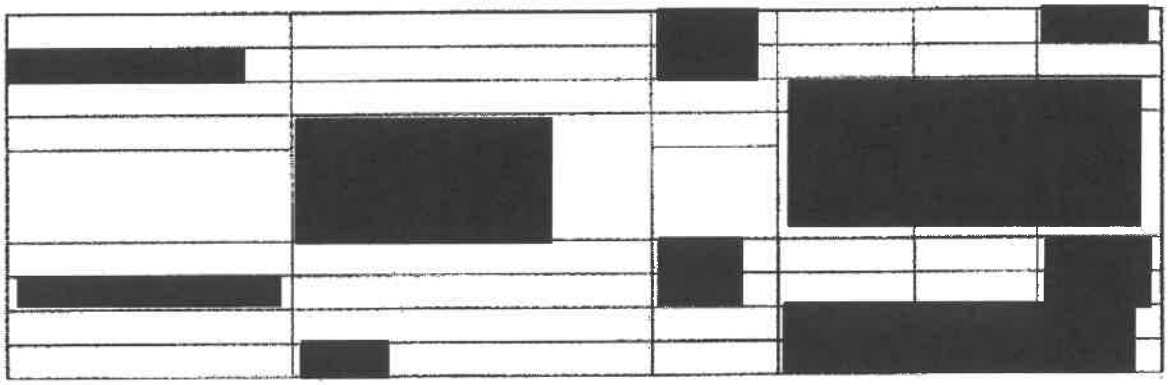
1. For failure to meet any of the satisfaction measures set forth in Exhibit 3, Section B.1 for the previous calendar year, [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous year, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee

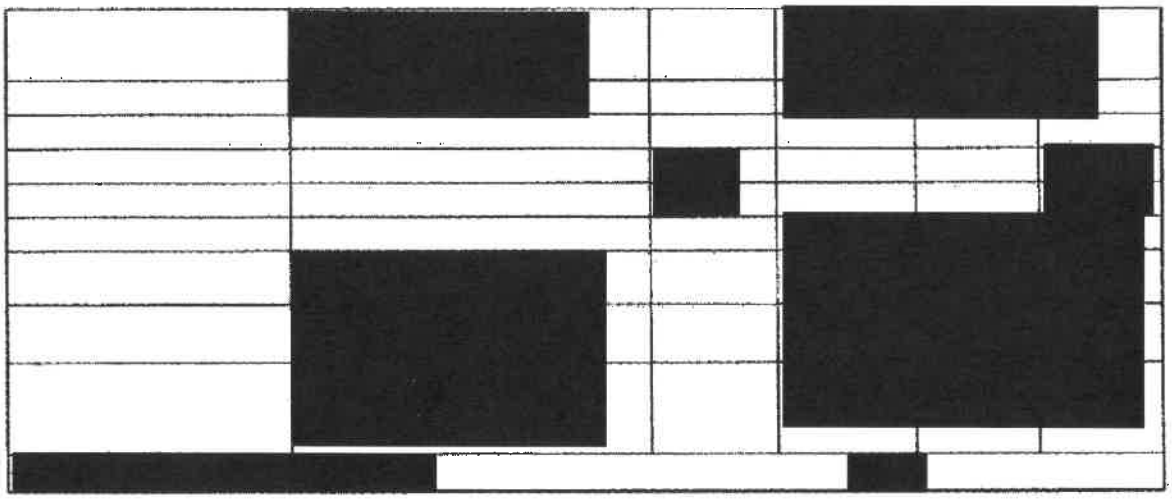
2. For failure to meet any of the call center measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.2: [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous month, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

3. For failure to meet the pre-certification turn-around-time and Adverse Determination overturn measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.3: [redacted] of the annualized Administrative Payment Amounts (excluding the Sleep Administrative Services Fee) payable by Company during the previous quarter, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

4. For failure to meet the pre-certification turn-around-time overturn measures for the Sleep Program when averaged for the calendar year measured as set forth in Exhibit 3, Section B.4: [redacted] of the annualized Sleep Administrative Services Fee payable by Company during the previous quarter.

5. Example. Delegated Entity performance results are measured after the Program Year has been completed. Those results become published ninety (90) days at the completion of the Program Year. The results at end of the Program Year show the following:





6. Implementation Costs. Delegated Entity shall pay Company the actual costs incurred by Company, but no more than [redacted] towards Company's implementation costs of the radiology management program ("Implementation Fee"). Delegated Entity shall pay a first installment of [redacted] of the Implementation Fee no later than 15 days after this Agreement's signature. Delegated Entity shall pay second and subsequent installments of the Implementation Fee, if needed, each year thereafter.

Exhibit A.1

Individual Sites Regulatory Compliance Addendum (ABH-Michigan)

PROGRAM PARTICIPATION SCHEDULE

Delegated Entity agrees to participate in the ABH-Michigan Plans and other health benefit programs listed herein:

- Those Medicaid and CHIP (Children's Health Insurance Program) Plans and programs offered by Company within the State of Michigan
- Those Medicare-Medicaid Plans offered by Company within the State of Michigan

Exhibit A.2

Individual Sites Regulatory Compliance Addendum (Michigan)

Governing Medicaid and CHIP Services

This Regulatory Compliance Addendum Governing Medicaid and CHIP Services (the "Michigan Medicaid/CHIP Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under, as applicable, (1) the Comprehensive Health Care Program contract (the "CHCP Contract") between the Michigan Department of Health and Human Services ("MDHHS") and Aetna Better Health of Michigan Inc. ("Company"), or (2) the *MIChild* Contract between MDHHS and Company (the "*MIChild* Contract"), under both of which contracts Company serves as a managed-care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the CHCP Contract and/or *MIChild* Contract.

The State of Michigan and/or MDHHS (the "State") requires that specific terms and conditions be incorporated into the Agreement because the Agreement is a contract between a health maintenance organization and its provider or subcontractor. As such, this Michigan Medicaid/CHIP Addendum is incorporated by reference into the Agreement between Company and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof), and such provider, vendor, contractor, or other entity must comply with the requirements set forth herein. Note that this Michigan Medicaid/CHIP Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in Company's policies, procedures, and provider manual. This Michigan Medicaid/CHIP Addendum and the Agreement may be revised as directed by the State.

For purposes of this Michigan Medicaid/CHIP Addendum, the individuals who are enrolled with Company under the CHCP Contract and/or the *MIChild* Contract will be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Michigan Medicaid/CHIP Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Michigan Medicaid/CHIP Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Michigan Medicaid/CHIP Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under, as applicable, the CHCP Contract or the *MIChild* Contract, and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the CHCP Contract and/or *MIChild* Contract. Except as provided herein, all other provisions of the Agreement not inconsistent with this Michigan Medicaid/CHIP Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Michigan Medicaid/CHIP Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The provider, vendor, contractor, or other entity identified on the first page of the Agreement acknowledges and agrees that all provisions of this Michigan Medicaid/CHIP Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members who are eligible and covered under, as applicable, the CHCP Contract or the *MIChild* Contract, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the CHCP Contract and/or *MIChild* Contract, and it/they represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Michigan Medicaid/CHIP Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

A. Definitions and Applicability

1. The requirements set forth below in **Section C** of this Michigan Medicaid/CHIP Addendum ("Additional Requirements Applicable to Contracts and Services Under the CHCP Contract") apply to contracts, Covered Services, and related administrative or health-benefit management services/functions under the CHCP Contract, and the following definitions shall apply with respect to those requirements:

a. "Provider" – A health facility or person that is licensed, certified, or registered under parts 61 to 65 or 161 to 182 of Michigan's Public Health code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211, and that provides healthcare services to Members. [CHCP, "Definition of Terms"]

b. "Subcontractor" – Any person or entity that performs a required, ongoing administrative or health-benefit management function of Company under the CHCP Contract, including without limitation: (1) "Health Benefit Managers," which include any entity that administers, manages, or arranges for the provision of one or more of the healthcare benefits that are covered under the CHCP Contract (including Pharmacy Benefit Managers, Behavioral Health Benefit Managers, and Vision Benefit Managers, but excluding Transportation Subcontractors); (2) "Administrative Subcontractors," which include any entity that performs, on behalf of Company, one or more administrative functions required under the CHCP Contract (including claims payment, third-party liability, delegated credentialing, utilization management, case management, card production, and mailing services); and (3) "Transportation Subcontractors," which include any entity that arranges and/or provides transportation services that are covered under the CHCP Contract (including any related health-benefit management services related to those transportation services). [CHCP, "Definition of Terms" and CHCP 2.070]

c. "Subcontract" – A written contract between Company and a Subcontractor to perform any of Company's administrative or health-benefit management obligations under the CHCP Contract.

2. The requirements set forth below in **Section D** of this Michigan Medicaid/CHIP Addendum ("Additional Requirements Applicable to Contracts and Services Under the *MIChild* Contract") apply to contracts, Covered Services, and related administrative or health-benefit management services/functions under the *MIChild* Contract, and the following definitions shall apply with respect to those requirements:

a. "Provider" – Those providers contracted with Company's health plan that are responsible for providing health care for Members. [CHCP, "Definition of Terms"]

b. "Subcontractor" – Any person or entity that performs a required, ongoing core function of Company under the *MIChild* Contract, with the exception of medical providers that are included in Company's provider network (which are not considered Subcontractors). In addition, counterparties with which Company contracts for one-time-only functions or services, such as maintenance or insurance protection, are not considered Subcontractors. [CHCP, "Definition of Terms"]

c. "Subcontract" – A written contract between Company and a Subcontractor to perform any of Company's administrative obligations under the *MIChild* Contract, with the exception of medical provider contracts, which are not considered Subcontracts. [CHCP, "Definition of Terms"]

3. The requirements set forth below in **Section B** of this Michigan Medicaid/CHIP Addendum ("General Requirements Applicable to Contracts and Services Under Both the CHCP Contract and the *MIChild* Contract") apply to contracts, Covered Services, and related administrative or health-benefit management services/functions under both the CHCP Contract and the *MIChild* Contract (as the case may be with respect to the particular services provided), and the respective definitions set forth above in this **Section A** shall apply with respect to those requirements.

B. General Requirements Applicable to Contracts and Services Under Both the CHCP Contract and the *MIChild* Contract

1. Compliance with Law. Provider/Subcontractor must be in compliance with all State statutes and federal and local laws and ordinances in providing the services under the Agreement, and shall fulfill the requirements of the CHCP Contract/*MIChild* Contract (as the case may be) and of Title XXI of the Social Security Act that are appropriate to the service or activity delegated, and will be subject to the provisions thereof. [*MIChild* I-F; CHCP 2.212]

2. Media Releases. News releases (including promotional literature and commercial advertisements) pertaining to the Agreement, the CHCP Contract, and/or the *MIChild* Contract, or any related project, must not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State, which Company shall be responsible to attempt to obtain. No results of the activities associated with the Agreement, the CHCP Contract, and/or the *MIChild* Contract are to be released without prior written approval of the State and then only to persons designated. [CHCP 2.031; *MIChild* I-G]

3. Non-discrimination. In the performance of the Agreement, Subcontractor agrees not to discriminate against any employee or applicant for employment, with respect to his or her hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability. Subcontractor further agrees that every Subcontract entered into for the performance related to this Agreement or the CHCP Contract/*MIChild* Contract or any Purchase Order resulting from the CHCP Contract/*MIChild* Contract will contain a provision requiring non-discrimination in employment, as specified here, binding upon each subcontractor used by Subcontractor. This covenant is required under the Elliot Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101 *et seq.*, and the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101 *et seq.*, and any breach of this provision may be regarded as a material breach of the Agreement, as amended, and the CHCP Contract/*MIChild* Contract. [CHCP 2.201; *MIChild* I-U]

4. Unfair Labor Practices. Under 1980 PA 278, MCL 423.321 *et seq.*, the State must not award a contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled under Section 2 of the Social Security Act. This information is compiled by the United States National Labor Relations Board. Subcontractor, in relation to the Agreement and the CHCP Contract/ *MIChild* Contract, must not enter into a contract with a subcontractor, manufacturer, or supplier whose name appears in this register. Under Section 4 of 1980 PA 278, MCL 423.324, the State may void any contract if, after award of the CHCP Contract/*MIChild* Contract, the name of Subcontractor as an employer or the name of a subcontractor, manufacturer, or supplier of Company or Subcontractor appears in the register. [CHCP 2.202; *MIChild* I-Z]

5. Independent Contractor. The relationship between the State and Company is that of client and independent contractor. Subcontractor shall not be deemed to be an employee, agent, or servant of the State for any reason. [CHCP 2.027; *MIChild* I-Y]

6. Transition Plan. Subcontractor shall cooperate in the event the State requires a transition plan setting forth the specific tasks and schedule to be accomplished by the parties to effect an orderly transition. In the event the State requires the services of Subcontractor as necessary to meet its needs, Subcontractor agrees to reasonably, and with good faith, work with the State and Company. [CHCP 2.172; *MIChild* I-R]

7. Member Hold Harmless. Provider/Subcontractor shall look only to Company for compensation for services rendered to a Member when such services are covered by the Plan. Provider/Subcontractor agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against a Member or person acting on behalf of a Member (other than Company), except to the extent that Copayments, Coinsurances, and Deductibles are specified in the Plan or as permitted pursuant to coordination of benefits. (All Copayments, Coinsurances, and Deductibles shall be applied by Company in accordance with applicable law, including without limitation MCL 500.3515.) Provider/Subcontractor agrees not to maintain any action at law or in equity against a Member to collect sums that are owed by Company to such Provider/Subcontractor under the terms of the Agreement, even in the event Company fails to pay,

becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This Section shall survive termination of the Agreement, regardless of the cause of termination and shall be construed to be for the benefit of the Member. This Section is not intended to apply to services provided after this Agreement has been terminated, except as otherwise provided in this Agreement, or to Non-Covered Services. Provider/Subcontractor further agrees that this provision supersedes any oral or written agreement, hereinafter entered into between such Provider/Subcontractor and Member or persons acting on Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement. Any modification, addition, or deletion to the provisions of this Section shall become effective on a date no earlier than sixty (60) days after the State Department of Insurance and Financial Services has received and approved such change. [See generally MI ADC R. 325.6345(2); CHCP 1.022U; *MIChild* II-M.5(c)]

8. Cooperation Regarding Data. Provider/Subcontractor must cooperate with Company so that Company can provide and cooperate with the State in the validation of data, and Provider/Subcontractor must make available all medical records and a sample of data and data collection protocols. [*MIChild* II-W; CHCP 1.042]

9. Company Is Sole Point of Contact. Company shall be the sole point of contact for the State with regard to all contractual matters under the CHCP Contract/*MIChild* Contract, including payment of any and all charges for services that Provider/Subcontractor provides in connection therewith. [*MIChild* I-F; CHCP 2.071]

10. Public Presentations. Provider/Subcontractor must obtain the State's written approval prior to publishing, or making formal public presentations of, statistical or analytical material based on its Enrollees other than as required by statute, regulation, or the CHCP Contract and/or *MIChild* Contract. [*MIChild* II-X; CHCP 1.042(b)]]

11. Marketing Materials. Subcontractor understands and agrees that all written and oral marketing materials and health promotion incentive materials must be approved by the State prior to use. In the event Subcontractor desires to utilize written and oral marketing materials related to its services under the Agreement, Subcontractor shall provide such materials to Company for submission to the State. Upon receipt by the State of a complete request for approval that proposes allowed marketing practices and locations, the State will provide a decision to Company within 30 business days or the request will be deemed approved. The review clock will be tolled while State-requested revisions to materials are being prepared for re-submission. Marketing materials must be available in languages appropriate to the Members being served within the county. All material must be culturally appropriate and available in alternative formats in accordance with the American with Disabilities Act. Subcontractor understands and agrees that the State may impose monetary or restricted enrollment sanctions if Subcontractor engages in prohibited marketing practices or uses marketing materials that have not been approved in writing by the State. Materials must be written at no higher than a 6.9 grade reading level as determined by any one of the following indices:

- Flesch – Kincaid
- Other computer generated readability indices accepted by the State

[CHCP 1.022(CC)(5); MIChild II-S]

12. Additional Provisions. In the event Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement, or in the event you are a Provider, your Agreement with Company hereby incorporates, and you shall ensure that your contracts with any of your downstream subcontractors or providers incorporate, the following requirements:

a. Provider/Subcontractor shall not seek payment from Enrollees for services provided, except for applicable co-payments and deductibles, which may be collected directly from Enrollees. [MI ADC R. 325.6345(2); MI Ins. Code 500.3529(3)]

b. Provider/Subcontractor shall meet applicable licensure or certification requirements. [MI ADC R. 325.6345(3)(a); MI Ins. Code 500.3529(4)(a)]

c. Provider/Subcontractor shall allow appropriate access to records or reports concerning services to Enrollees. [MI ADC R. 325. 6345(3)(b); MI Ins. Code 500.3529(4)(b).]

d. Provider/Subcontractor shall cooperate with Company's quality assurance, quality improvement, and utilization review activities. [MI ADC R. 325. 6345(3)(c); MI Ins. Code 500.3529(4)(c); CHCP 1.022U(1)(b); *MIChild* II-M.5(c)]

e. Pursuant to Title XXI of the Social Security Act, payment under Title XXI shall not be made for services furnished by providers who have been excluded from participation under Title V, Title XVIII, Title XIX, or Title XX of the Social Security Act. [*MIChild* II-J.3; CHCP Change Notice No. 5 (section 9)]

f. In the event of Company's insolvency, Provider/Subcontractor agrees to continue providing services to Members. Company acknowledges that it is required by law to provide a mechanism for appropriate sharing of the continuation of provider services as approved by the Michigan Insurance Commissioner and in no event shall such continuation be solely the responsibility of the provider. [MI Ins. Code 500.3561]

g. Unless this Agreement is terminated for cause, upon termination of this Agreement, Provider/Subcontractor shall continue to furnish Covered Services under the Agreement for a period not to exceed ninety (90) days following termination where the continuation of care is medically necessary and prudent, including without limitation, circumstances such as disability, pregnancy, or life-threatening illness. Provider/Subcontractor shall neither charge nor hold Members financially responsible for any Covered Services rendered other than for applicable deductibles or copayments, and shall be paid for Covered Services rendered at the rate that is in effect between the parties during the period immediately preceding termination on the bases referenced herein. This subsection shall be construed in favor of the Member, shall survive the termination of this Agreement regardless of the reason for termination, and shall supersede any oral or written agreement to the contrary between Provider/Subcontractor and a Member or a Member's representative. [*MIChild* II-M.5(c) and general member-protection provisions]

h. If applicable, Provider/Subcontractor shall provide for the immediate transfer of Enrollees to another network provider/primary-care provider if the Enrollees' health or safety is in jeopardy. [CHCP 1.022U(1)(c); *MIChild* II-M.5(c)]

i. Provider/Subcontractor shall agree to comply with all applicable State and federal requirements, regulations, and laws, including, but not limited to, rules and regulations of CMS and of any other federal agencies and any State agencies of the State(s) in which Provider/Subcontractor practices. Provider/Subcontractor understands and agrees that CMS and the appropriate State agencies may change or add to such requirements, laws, rules, and regulations from time to time. [See CHCP 1.022; CHCP 2.212; *MIChild* II-B]

j. Provider/Subcontractor shall comply with all reporting requirements for communicable diseases and other health indicators. [*MIChild* II-J(2); CHCP 1.022(F)]

k. Providers/Subcontractors are not prohibited from discussing treatment options with Members that may not reflect Company's position or that may not be covered by Company. Providers/Subcontractors acting within the lawful scope of practice are not prohibited, or otherwise restricted, from advising or advocating on behalf of an Enrollee who is his or her patient regarding: (a) the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (b) any information the Enrollee needs in order to decide among all relevant treatment options; (c) the risks, benefits, and consequences of treatment or non-treatment; (d) the Enrollee'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; (e) Medically Necessary and appropriate care with or on behalf of an Enrollee, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultation or tests, regardless of benefit coverage limitations; (f) the process that Company or any entity contracting with Company uses or

proposes to use to deny payment for a health care service; (g) the decision of any managed care plan to deny payment for a health care service; or (h) advocating on behalf of the Enrollee in any grievance or utilization review process or Enrollee authorization process to obtain Covered Services. [CHCP 1.022U(1)(d); *MIChild* II-M.5(c); CHCP FY 2013(13) amendment]

13. Clean Claim. The definition of Clean Claim that is set forth in the Agreement shall additionally include the applicable Michigan statutory requirements set forth in MCL 400.111*i*(2)(a). Company shall pay all Clean Claims in accordance with the terms and requirements set forth in MCL 400.111*i*.

14. Governing Law. Notwithstanding anything to the contrary in the Agreement, the laws of the State of Michigan shall govern the Agreement as it relates to Company (namely, Aetna Better Health of Michigan Inc.) and to all Covered Services that Provider provides to Company's Members, regardless of where Provider is located.

C. Additional Requirements Applicable to Contracts and Services Under the CHCP Contract

1. Access to and Ownership of Data. The State is the owner of all data made available by the State to Company or its agents, subcontractors, or representatives under the CHCP Contract. Neither Company nor Provider/Subcontractor shall use the State's data for any purpose other than providing the services under the CHCP Contract, nor will any part of the State's data be disclosed, sold, assigned, leased, or otherwise disposed of to the general public or to specific third parties or commercially exploited by or on behalf of Company or Provider/Subcontractor. No employees of Provider/Subcontractor, other than those on a strictly need-to-know basis, shall have access to the State's data. Provider/Subcontractor will not possess or assert any lien or other right against the State's data. Without limiting the generality of this Section, Provider/Subcontractor must only use personally identifiable information as strictly necessary to provide the services under the Agreement and the CHCP Contract and must disclose the information only to its employees on a strict need-to-know basis. Provider/Subcontractor must comply at all times with all laws and regulations applicable to the personally identifiable information. The State is the owner of all State-specific data under the CHCP Contract. The State may use the data provided by Provider/Subcontractor, directly or indirectly, for any purpose. The State will not possess or assert any lien or other right against Provider/Subcontractor's data. Without limiting the generality of this Section, the State may use personally identifiable information only as strictly necessary to utilize the services under the CHCP Contract and must disclose the information only to its employees on a strict need-to-know basis, except as provided by law. The State must comply at all times with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property. [CHCP 1.042(B)]

2. Personnel Qualifications. All persons assigned by Subcontractor to the performance of services related to the CHCP Contract must be employees of Subcontractor or its majority-owned (directly or indirectly, at any tier) subsidiaries (or a State-approved subcontractor) and must be fully qualified to perform the work assigned to them. For the purposes of the Agreement and this Michigan Medicaid/CHIP Addendum, independent contractors engaged by Subcontractor solely in a staff augmentation role must be treated by the State as if they were employees of Subcontractor for purposes of the Agreement and the CHCP Contract only; however, the State understands that the relationship between Company and Subcontractor is an independent contractor relationship. Subcontractor's personnel must cooperate with the State and its agents and other contractors including the State's Quality Assurance personnel. As reasonably requested by the State in writing, Subcontractor will provide to the State's agents and other contractors reasonable access to its project personnel, systems, and facilities to the extent the access relates to activities specifically associated with the CHCP Contract will not interfere or jeopardize the safety or operation of the systems or facilities. [CHCP 2.061; 2.066]

3. CHCP Contract Binding. Subcontractor, to the extent it is performing services under the Agreement or related to the CHCP Contract, shall be bound to Company by the terms of the CHCP Contract and shall assume all of the obligations and responsibilities that Company, by the CHCP Contract, assumes toward the State. The State reserves the right to receive copies of and review all Subcontracts, although Company may delete or mask any proprietary information, including pricing, contained in such contracts before providing them to the State. The State's written approval of Subcontractor to perform any obligation under the

CHCP Contract shall not relieve Company or Subcontractor of any obligations or performance required under the CHCP Contract. [CHCP 2.073]

4. Confidentiality. [CHCP 2.100–2.105]

a. Company and Provider/Subcontractor each acknowledge that the other possesses and will continue to possess confidential information that has been developed or received by it. As used in this Section, "Confidential Information" means all non-public proprietary information of Company or Provider/Subcontractor (other than Confidential Information of the State as defined below) which is marked confidential, restricted, proprietary, or with a similar designation. "Confidential Information" of the State means any information that is retained in confidence by the State (or otherwise required to be held in confidence by the State under applicable federal, State, and local laws and regulations) or that, in the case of tangible materials provided to Company or Provider/Subcontractor by the State under its performance under the CHCP Contract, is marked as confidential, proprietary, or with a similar designation by the State. "Confidential Information" excludes any information (including the CHCP Contract) that is publicly available under the Michigan FOIA.

b. Company and Provider/Subcontractor will each use at least the same degree of care to prevent disclosing to third parties the Confidential Information of the other as it employs to avoid unauthorized disclosure, publication or dissemination of its own confidential information of like character, but in no event less than reasonable care. Neither Company nor Provider/Subcontractor will (i) make any use of the Confidential Information of the other except as contemplated by this Michigan Medicaid/CHIP Addendum, (ii) acquire any right in or assert any lien against the Confidential Information of the other, or (iii) if requested to do so, refuse for any reason to promptly return the other party's Confidential Information to the other party. Each party will limit disclosure of the other party's Confidential Information to employees and subcontractors who must have access to fulfill the purposes of the Agreement and the CHCP Contract. Disclosure to, and use by, a subcontractor is permissible where (A) use of a subcontractor is authorized under the Agreement and the CHCP Contract, (B) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the subcontractor's scope of responsibility, and (C) the subcontractor is obligated in writing to maintain the State's, Company's, and/or Provider/Subcontractor's Confidential Information in confidence. At the State's request, any employee of Provider/Subcontractor having access or continued access to the State's Confidential Information may be required to execute an acknowledgment that the employee has been advised of Company's and Provider/Subcontractor's obligations under this section and of the employee's obligation to Company or Provider/Subcontractor, as the case may be, to protect the Confidential Information from unauthorized use or disclosure. Promptly upon termination or cancellation of this Agreement or the CHCP Contract for any reason, Provider/Subcontractor must certify to the State and/or Company that Provider/Subcontractor has destroyed all Confidential Information of the State or Company.

c. Notwithstanding the foregoing, the provisions of subsections 4.a and 4.b above will not apply to any particular information that the State, Company, or Provider/Subcontractor can demonstrate (i) was, at the time of disclosure to it, in the public domain; (ii) after disclosure to it, is published or otherwise becomes part of the public domain through no fault of the receiving party; (iii) was in the possession of the receiving party at the time of disclosure to it without an obligation of confidentiality; (iv) was received after disclosure to it from a third party who had a lawful right to disclose the information to it without any obligation to restrict its further disclosure; or (v) was independently developed by the receiving party without reference to Confidential Information of the furnishing party. Furthermore, the provisions of subsections 4.a and 4.b above will not apply to any particular Confidential Information to the extent the receiving party is required by law to disclose the Confidential Information, provided that the receiving party (i) promptly provides the furnishing party with notice of the legal request, and (ii) assists the furnishing party in resisting or limiting the scope of the disclosure as reasonably requested by the furnishing party.

d. Nothing contained in this Section shall be construed as obligating a party to disclose any particular Confidential Information to the other party, or as granting to or conferring on a party, expressly or impliedly, any right or license to the Confidential Information of the other party.

e. The parties' respective obligations under this Section must survive the termination or expiration of this Michigan Medicaid/CHIP Addendum, the Agreement, and the CHCP Contract for any reason.

[CHCP 2.100–105]

5. Inspection of Work Performed. Subcontractor acknowledges and agrees that the State's authorized representatives must at all reasonable times, and with ten (10) days' prior written request, have the right to enter Subcontractor's premises, or any other places, where the services performed under this Agreement or the CHCP Contract are being performed, and must have access, upon reasonable request, to interim drafts of any deliverables related to this Agreement or the CHCP Contract, or work-in-progress. Upon ten (10) days' prior written notice and at all reasonable times, the State's representatives must be allowed to inspect, monitor, or otherwise evaluate the work being performed and to the extent that the access will not reasonably interfere or jeopardize the safety or operation of the systems or facilities. Subcontractor must provide all reasonable facilities and assistance for the State's representatives. [CHCP 2.111]

6. Examination of Records. For seven (7) years after Subcontractor provides any work under the CHCP Contract or the Agreement (the "Audit Period"), the State and/or federal representatives may examine and copy any of Subcontractor's books, records, documents, and papers pertinent to establishing Subcontractor's compliance with the CHCP Contract and with applicable laws and rules. The State and/or federal representatives must notify Subcontractor twenty (20) days before examining Subcontractor's books and records. This provision also applies to the books, records, accounts, documents, and papers, in print or electronic form, of any parent, affiliated, or subsidiary organization of Subcontractor performing services in connection with the Agreement or CHCP Contract. [CHCP 2.112]

7. Retention of Records. Subcontractor must maintain at least until the end of the Audit Period all pertinent financial and accounting records (including time sheets and payroll records, and information pertaining to the Agreement or CHCP Contract, equipment, and commodities provided under the Agreement or CHCP Contract) pertaining to the Agreement or CHCP Contract according to generally accepted accounting principles and other procedures specified in this Section. Financial and accounting records must be made available, upon request, to the State and/or federal representatives at any time during the Audit Period. If an audit, litigation, or other action involving Subcontractor's records is initiated before the end of the Audit Period, the records must be retained until all issues arising out of the audit, litigation, or other action are resolved or until the end of the Audit Period, whichever is later. [CHCP 2.113]

8. Audit Resolution. If necessary, Company, Subcontractor, and the State will meet to review each audit report promptly after issuance. Subcontractor will respond, either directly to the State, or indirectly through Company, to each audit report in writing within thirty (30) days from receipt of the report, unless a shorter response time is specified in the report. Company, Subcontractor, and the State must develop, agree upon, and monitor an action plan to promptly address and resolve any deficiencies, concerns, and/or recommendations in the audit report. [CHCP 2.114]

a. If the audit demonstrates any errors in the documents provided to the State or Company, then the amount in error will be reflected as a credit or debit on a future pay cycle and in subsequent pay cycles until the amount is paid or refunded in full. [CHCP 2.115]

b. In addition to other available remedies, if the difference between the payment received and the correct payment amount is greater than 10%, then Subcontractor must pay all of the reasonable costs of the audit. [CHCP 2.115]

9. Warranties and Representations. [CHCP 2.120–2.127] Subcontractor represents and warrants that, with respect to the services that it is contractually required to provide to Company under the Agreement:

a. It is capable in all respects of fulfilling and must fulfill all of its obligations under the Agreement and the CHCP Contract. The performance of all obligations must be provided in a timely,

professional, and workman-like manner and must meet the performance and operational standards required under the Agreement or CHCP Contract.

b. The CHCP Contract (Appendices, Attachments and Exhibits) identifies the equipment and software and services necessary to perform and to operate in compliance with the CHCP Contract requirements and other standards of performance.

c. It is the lawful owner or licensee of any Deliverable (as defined by the CHCP Contract) licensed or sold to the State or Company or developed by Subcontractor under the CHCP Contract, and Subcontractor has all of the rights necessary to convey to the State the ownership rights or licensed use, as applicable, of any and all Deliverables. None of the Deliverables provided by Subcontractor to the State under the CHCP Contract, nor their use by the State, will infringe the patent, copyright, trade secret, or other proprietary rights of any third party.

d. If, under the CHCP Contract or the Agreement, Subcontractor procures any equipment, software, or other Deliverable for the State (including equipment, software and other Deliverables manufactured, re-marketed or otherwise sold by Subcontractor under Subcontractor's name), then in addition to Subcontractor's other responsibilities with respect to the items in the CHCP Contract, Subcontractor must assign or otherwise transfer to the State or its designees, or afford the State the benefits of, any manufacturer's warranty for the Deliverable.

e. Subcontractor's signatory has the power and authority, including any necessary corporate authorizations, necessary to enter into this Agreement, on behalf of Subcontractor.

f. It is qualified and registered to transact business in all locations where required.

g. Neither Subcontractor nor any affiliates, nor any employee of either, has, must have, or must acquire, any contractual, financial, business, or other interest, direct or indirect, that would conflict in any manner or degree with Subcontractor's performance of its duties and responsibilities to the State under the CHCP Contract or otherwise create an appearance of impropriety with respect to the award or performance of the CHCP Contract. Subcontractor must notify Company and the State about the nature of the conflict or appearance of impropriety within two days of learning about it.

h. Neither Subcontractor nor any affiliates, nor any employee of either, has accepted or must accept anything of value based on an understanding that the actions of Subcontractor or its affiliates or employees on behalf of the State would be influenced. Subcontractor must not attempt to influence any State employee by the direct or indirect offer of anything of value.

i. Neither Subcontractor nor any affiliates, nor any employee of either, has paid or agreed to pay any person, other than bona fide employees and consultants working solely for Subcontractor or the affiliate, any fee, commission, percentage, brokerage fee, gift, or any other consideration, contingent upon or resulting from the award or making of the CHCP Contract.

j. All financial statements, reports, and other information furnished by Subcontractor (if any) to the State in connection with the award of the CHCP Contract fairly and accurately represent the business, properties, financial condition, and results of operations of Subcontractor as of the respective dates, or for the respective periods, covered by the financial statements, reports, other information. Since the respective dates or periods covered by the financial statements, reports, or other information provided to the State (if any), there have been no material adverse change in the business, properties, financial condition, or results of operations of Subcontractor.

k. All written information furnished to Company or the State by or for Subcontractor in connection with the CHCP Contract, is true, accurate, and complete, and contains no untrue statement of material fact or omits any material fact necessary to make the information not misleading.

l. It is not in material default or breach of any other contract or agreement that it may have with the State or any of its departments, commissions, boards, or agencies. Subcontractor further represents and warrants that it has not been a party to any contract with the State or any of its departments that was terminated by the State or the department within the previous five years for the reason that Subcontractor failed to perform or otherwise breached an obligation of the CHCP Contract.

m. If any of the certifications, representations, or disclosures relating to Subcontractor (if any) made in Company's original bid response change after the award of the CHCP Contract, the Subcontractor is required to report those changes immediately.

[CHCP 2.120–127]

10. Consequences for Breach of Warranties and Representations. In addition to any remedies available in law, if Subcontractor breaches any of the warranties contained in Subsection C.9 above, the breach may be considered as a default in the performance of a material obligation of the Agreement, as amended. [CHCP 2.128]

11. Workplace Safety and Discriminatory Harassment. In performing services under the Agreement and related to the CHCP Contract, and to the extent Subcontractor has employees in the State of Michigan, Subcontractor must comply with the Department of Civil Services Rule 2-20 regarding Workplace Safety and Rule 1-8.3 regarding Discriminatory Harassment. In addition, Subcontractor must comply with Civil Service regulations and any applicable agency rules provided to the Contractor. For Civil Service Rules, see www.mi.gov/mdcs/0,1607,7-147-6877---,00.html. [CHCP 2.203]

12. Disclosure of Litigation and Other Events. Subcontractor must disclose any material criminal litigation, investigations, or proceedings involving Subcontractor (and each of its subcontractors) or any of its officers or directors or any litigation, investigations, or proceedings under the Sarbanes-Oxley Act. In addition, Subcontractor (and each of its subcontractors) must notify Contractor of any material civil litigation, arbitration, or proceeding that arises during the term of the Agreement or the CHCP Contract and extensions, to which Subcontractor (or, to the extent Subcontractor is aware, any subcontractor) is a party, and that involves: (i) disputes that might reasonably be expected to adversely affect the viability or financial stability of Subcontractor or any of its subcontractors; or (ii) a claim or written allegation of fraud against Subcontractor or, to the extent Subcontractor is aware, any of its subcontractors by a governmental or public entity arising out of their business dealings with governmental or public entities. Subcontractor must disclose in writing to Company any litigation, investigation, arbitration, or other proceeding (collectively, "Proceeding") within thirty (30) days of its occurrence. Details of settlements that are prevented from disclosure by the terms of the settlement may be annotated. Information provided to the State from Subcontractor's publicly filed documents referencing its material litigation will be deemed to satisfy the requirements of this Section. If any Proceeding disclosed to the State under this Section, or of which the State otherwise becomes aware, during the term of the CHCP Contract would cause a reasonable party to be concerned about: (i) the ability of Company, Subcontractor, or any of Subcontractor's subcontractors to continue to perform pursuant to the CHCP Contract or the Agreement according to their terms and conditions, or (ii) whether Company, Subcontractor, or any of Subcontractor's subcontractors in performing services for the State is engaged in conduct that is similar in nature to conduct alleged in the Proceeding, which conduct would constitute a breach of the Agreement or CHCP Contract or a violation of State law, regulations, or public policy, then Subcontractor must provide Company and the State all reasonable assurances requested by the State to demonstrate that: (a) Company, Subcontractor, and any of Subcontractor's subcontractors will be able to continue to perform the CHCP Contract according to its terms and conditions, and (b) Company, Subcontractor, or any of Subcontractor's subcontractors have not and will not engage in conduct in performing the services that is similar in nature to the conduct alleged in the Proceeding. Subcontractor must make the following notifications in writing: (1) Subcontractor must notify Company within fifteen (15) days of Subcontractor becoming aware that a change in its ownership or officers has occurred, or is certain to occur, or a change that could result in changes in the valuation of its capitalized assets in the accounting records; (2) Subcontractor must notify Company within fifteen (15) days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership or officers; and (3) Subcontractor must notify Company within thirty

(30) days whenever changes to company affiliations occur. In each of the aforementioned instances, Company shall notify the State as required. [CHCP 2.231]

13. Contract with the State. Subcontractor understands and agrees that upon a good-faith termination of the CHCP Contract, the State may assume, at its option, the Agreement between Company and Subcontractor, and may further pursue completion of the services/Deliverables under the CHCP Contract by replacement contract or otherwise as the State may in its sole judgment deem advantageous to the State. [CHCP 2.157]

14. False Claims. Subcontractor must comply with all applicable provisions of the federal False Claims Act and Michigan Medicaid False Claims Act. Actions taken to comply with the federal and State laws specifically include, but are not limited, to complying with and adopting Company's policies regarding the detection and prevention of waste, fraud, and abuse. [CHCP 1.022(L)(9)]

15. Annual Report. Subcontractor shall provide necessary information for Company to submit its required annual report, which shall include disclosure of applicable civil litigation. [CHCP 1.042]

16. State Approval of Subcontractors. Subcontractor understands and agrees that the State has the right of approval of Health Benefit Managers and Type A Transportation Subcontractors (as defined herein) and to require Company to replace any Heath Benefit Managers and Type A Transportation Subcontractors found, in the reasonable judgment of the State, to be unacceptable. The State's request will be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's request will be based on good-faith reasons. [2.072]

17. Services/Deliverables Covered. For all services/Deliverables to be provided by Company (and its Subcontractors) under the CHCP Contract, the State will not be obligated to pay any amounts in addition to the amounts set forth in the CHCP Contract. [CHCP 2.043]

18. Insurance.

a. Subcontractor shall purchase and maintain the insurance coverage as described in this Section in connection with the performance of work under the Agreement. The insurance must protect the State from claims that may arise out of or result from the Subcontractor's performance of services under the CHCP Contract, whether the services are performed by the Subcontractor or by anyone directly or indirectly employed by it, or by anyone for whose acts it may be liable. The Subcontractor waives all rights against the State, its departments, divisions, agencies, offices, commissions, officers, employees, and agents for recovery of damages to the extent these damages are covered by the insurance policies the Subcontractor is required to maintain under the CHCP Contract. All insurance coverage provided relative to the CHCP Contract must be PRIMARY and NON-CONTRIBUTING to any comparable liability insurance (including self-insurance) carried by the State. The insurance must be written for not less than any minimum coverage specified in this Section or required by law, whichever is greater. The insurers selected by Subcontractor must have an A.M. Best rating of A or better, or as otherwise approved in writing by the State, or if the ratings are no longer available, with a comparable rating from a recognized insurance rating agency. All policies of insurance required must be issued by companies that have been approved to do business in the State. (See www.michigan.gov/dleg.) Where specific limits are shown in this Section, they are the minimum acceptable limits. If Subcontractor's policy contains higher limits, the State must be entitled to coverage to the extent of the higher limits. [CHCP 2.131]

b. Subcontractor must furnish to Company certificates of insurance verifying insurance coverage or providing satisfactory evidence of self-insurance as required in this Section (the "Certificates"). The Certificates must be on the standard "accord" form or equivalent. All Certificates are to be prepared and submitted by the insurance provider. All Certificates must contain a provision indicating that coverages afforded under the policies WILL NOT BE CANCELLED, MATERIALLY CHANGED, OR NOT RENEWED without 30 days' prior written notice, except for 10 days for non-payment of premium, having been given to the Director of Purchasing Operations, Department of Management and Budget. The notice must include reference to the CHCP Contract. Subcontractor shall

provide Company with information necessary for Company to evidence to the State upon request, and not less than 20 days before the insurance expiration date every year, that the State and its agents, officers, and employees are listed as additional insureds under each commercial general liability and commercial automobile liability policy. In the event the State approves the representation of the State by the insurer's attorney, the attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan. [CHCP 2.133]

c. Subcontractor must maintain all required insurance coverage throughout the term of the Agreement and any extensions and, in the case of claims-made Commercial General Liability policies, must secure tail coverage for at least three years following the expiration or termination for any reason of Agreement. The minimum limits of coverage specified above are not intended, and must not be construed, to limit any liability or indemnity of Subcontractor to any indemnified party or other persons. Subcontractor is responsible for all deductibles with regard to the insurance. If the Subcontractor fails to pay any premium for required insurance, or if any insurer cancels or significantly reduces any required insurance without the State's written consent, Company reserves the right to be made whole by Subcontractor in the event the State pays the premium or procures similar insurance coverage from another company or companies and deducts any part of the cost from any payment due to Company, or in the event that the State requires Company to pay that cost upon demand by the State. [CHCP 2.133]

d. For purposes of this Section, the following definitions shall apply [see CHCP 2.070]:

(i) Transportation Subcontractor: An entity that arranges or arranges and provides transportation services covered under the CHCP Contract under a written subcontract with Company in the following categories:

I. Type A Transportation Subcontractors perform Health Benefit Management services for the transportation benefit. These Subcontractors do not directly provide the transportation benefit, but rather subcontract with other entities to provide the actual transportation.

II. Type B Transportation Subcontractors arrange and provide the transportation services, such as social or religious agencies that provide transportation to covered services.

(ii) Health Benefit Manager: An entity that arranges for the provision of health services covered under the Agreement, with the exclusion of transportation. Health Benefit Managers include, but are not limited to, Pharmacy Benefit Managers, Behavioral Health Benefit Managers, and Vision Benefit Managers.

(iii) Administrative Subcontractors are entities that perform, for Company, administrative functions required by this Agreement such as claims payment, delegated credentialing, and card production and mailing services, in the following categories:

I. Type A Administrative Subcontractors perform administrative functions for Company dealing with claims payment, third party liability, or other functions involving payment decisions.

II. Type B Administrative Subcontractors perform administrative functions relating to medical decisions such as credentialing, utilization management, or case-management.

III. Type C Administrative Subcontractors perform miscellaneous administrative functions required by this Agreement that do not involve payment or medical decisions. This type of administrative Subcontractor includes but is not limited to identification card production and mailing services.

e. Insurance Requirements for Health Benefit Managers and Type A Transportation Subcontractors [see CHCP 2.132]:

(i) Commercial General Liability with the following minimum coverage:

$2,000,000 General Aggregate Limit other than Products/Completed Operations
$2,000,000 Products/Completed Operations Aggregate Limit
$1,000,000 Personal & Advertising Injury Limit
$1,000,000 Each Occurrence Limit

Subcontractor must list the State, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as ADDITIONAL INSUREDS on the Commercial General Liability certificate. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

(ii) If a motor vehicle is used to provide services or products under the Agreement, Subcontractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Subcontractor's business for bodily injury and property damage as required by law. Subcontractor must list the State, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

(iii) Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Subcontractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Subcontractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur. Any certificates of insurance received must also provide a list of states where the coverage is applicable. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

(iv) Employers liability insurance with the following minimum limits:

$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

(v) Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by Subcontractor's employees acting alone or in collusion with others, in a minimum amount of one million dollars ($1,000,000.00) with a maximum deductible of fifty thousand dollars ($50,000.00).

(vi) Umbrella or Excess Liability Insurance in a minimum amount of five million dollars ($5,000,000.00), which must apply, at a minimum, to the insurance required in Subsection 19(c)(i) (Commercial General Liability) above.

(vii) Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: one million dollars ($1,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

f. Insurance Requirements for Type A – Administrative Subcontractors dealing with payment decisions [see CHCP 2.132]:

(i) If a motor vehicle is used to provide services or products under the Agreement, Subcontractor must have vehicle liability insurance on any auto including owned, hired, and non-owned vehicles used in Subcontractor's business for bodily injury and property damage as required by law. The Subcontractor must list the State, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

(ii) Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Subontractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Subcontractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur. Any certificates of insurance received must also provide a list of states where the coverage is applicable. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

(iii) Employers liability insurance with the following minimum limits:

$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

(iv) Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by the Subcontractor's employees, acting alone or in collusion with others, in a minimum amount of one million dollars ($1,000,000.00) with a maximum deductible of fifty thousand dollars ($50,000.00).

(v) Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: three million dollars ($3,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

g. Insurance Requirements for Type B Administrative Subcontractors dealing with medical decisions [see CHCP 2.132]:

(i) If a motor vehicle is used to provide services or products under the Agreement, Subcontractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Subcontractor's business for bodily injury and property damage as required by law. Subcontractor must list the State, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

(ii) Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of Subcontractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Subcontractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur. Any certificates of insurance received must also provide a list of states where the coverage is applicable.

Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

(iii) Employers liability insurance with the following minimum limits:

$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

(iv) Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: one million dollars ($1,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

h. Insurance Requirements for Type B Transportation Subcontractors: Type B Transportation Subcontractors must verify that individuals providing the transportation have secured appropriate insurance coverage as required by law. The subcontract with the Type B Transportation Subcontractor should require these Type B Transportation Subcontractors to obtain a letter of understanding with the individual providing the transportation that attests that the individual has appropriate insurance coverage. [CHCP 2.132]

19. Additional Provisions. In the event Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement, or in the event you are a Provider, your Agreement with Company hereby incorporates, and you shall ensure that your contracts with any of your downstream subcontractors or providers incorporate, the requirements set forth above in Subsection B.12 of this Michigan Medicaid/CHIP Addendum, as well as the following additional requirements:

a. Providers must be prohibited from seeking payment from an Enrollee for any covered services provided to that Enrollee within the terms of the CHCP Contract and must be required to look solely to the Subcontractor or Company, as applicable, for compensation for services rendered. No cost sharing or deductibles can be collected from Enrollees unless approved in writing by Company. [CHCP 1.022U(1)(a)]

b. Providers must be required to meet Medicaid accessibility standards as defined in the CHCP Contract. [CHCP 1.022U(1)(f)]

c. Providers must provide for continuity of treatment in the event a provider's participation terminates during the course of an Enrollee's treatment by that provider. [CHCP 1.022U(1)(g)]

d. If the Plan utilizes co-payments for the Covered Service, providers must be prohibited from denying services to an Enrollee who is eligible for the services due to the Enrollee's inability to pay the co-payment. [CHCP 1.022U(1)(h)]

e. Hospital contracts must contain a provision that mandates the hospital to comply with all medical record requirements contained within 42 C.F.R. §§ 456.101–456.145 [CHCP 1.022U(1)(i); FY 2012 amendment No. 18]

f. In accordance with Section 1932(b)(7) of the Social Security Act as implemented by Section 4704(a) of the Balanced Budget Act, Provider/Subcontractor may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as an "any willing provider" law, as it does not prohibit Provider/Subcontractor from limiting provider participation to the extent necessary to meet the needs of the enrollees. This provision also does not interfere with measures established by the Provider/Subcontractor that are designed to maintain quality and control costs consistent with the

responsibility of the organization. If Provider/Subcontractor declines to include providers in its network, Provider/Subcontractor must give the affected providers written notice of the reason for the decision. [CHCP 1.022U(2)]

g. In order for Company to comply with its contractual and legal obligations, Provider agrees to permit Subcontractor, Company, any federal or State agency having jurisdiction over Provider's provision of services to the Plan, the U.S. Department of Health and Human Services, and/or any accrediting organization to conduct periodic site evaluations of Provider's facilities, offices, and records. Upon Company's written request, Provider shall provide Company with a copy of the written response to any questions or comments posed by the agencies listed in the preceding sentence. [See generally CHCP 2.110]

h. During regular business hours and upon reasonable notice and demand, Company and/or Subcontractor shall have access to, and the right to audit and obtain copies of, Provider records within the possession of or reasonably accessible to, or under the control of Provider that are related to the services provided under this Agreement. Unless applicable statutes or regulations require a longer time period, Company and/or Subcontractor shall have such access during the term of this Agreement and for seven (7) years following its termination. All Provider records requested by Company and/or Subcontractor shall be provided within no more than seven (7) days from the date such request is made, except in the case of an audit or site visit by Company and/or Subcontractor where records or copies of records shall be provided at the time of the audit or site visit. Provider's refusal to grant access to Provider records as requested by Company and/or Subcontractor or as required by any federal or State law or regulations shall constitute a breach of this Agreement and may result in the imposition of sanctions including termination and/or financial penalties. [CHCP 2.110]

i. Providers shall comply with State and federal law and Company policy to enable Members to make decisions concerning their medical care, including the right to accept or refuse medical treatment and the right to formulate, at the Members option, advanced directives. [CHCP 1.022(L)(7)]

D. Additional Requirements Applicable to Contracts and Services Under the *MIChild* Contract

1. Disclosure of Ownership. Subcontractor must cooperate with Company so that Company can fulfill its requirements under the *MIChild* Contract to (a) disclose and submit ownership information between Company and any person with control or ownership of five percent (5%) or more in a Subcontract, and (b) supply upon request of the federal or State government a description of the transactions (if any) between Company and any person with control or ownership of five percent (5%) or more in a Subcontractor. [*MIChild* I-F]

2. Insurance. Subcontractors shall maintain insurance coverage as specified in this Section and shall provide proof, upon the State's request and if applicable, of medical professional liability insurance in amounts consistent with Company's provider network standards for similar professionals. Specifically, the Subcontractor shall purchase and maintain such insurance as will protect it from the claims set forth below that may arise out of or result from the Subcontractor's operations under the *MIChild* Contract, whether such operations are by the Subcontractor or by anyone directly or indirectly employed by it, or by anyone for whose acts any of them may be liable:

a. Claims under workers' compensation, disability benefit, and other similar employee benefit act. A non-resident Subcontractor shall have insurance for benefits payable under the State's Workers' Disability Compensation Law for any employee resident of and hired in the State, and as respects any other employee protected by workers' disability compensation laws of any other state the Subcontractor shall have insurance or participate in a mandatory state fund to cover the benefits payable to any such employee. Subcontractor shall provide workers' compensation insurance for all its employees working in the State, unless its employees are covered by the workers' compensation protection afforded by Company. Any Subcontract executed with a person or entity not having the requisite workers' compensation coverage will be considered void by the State. [*MIChild* I-P.1]

b. Claims for damages because of bodily injury, occupational sickness or disease, or death of its employees. [*MIChild* I-P.2]

c. Claims for damages because of bodily injury, sickness or disease, or death of any person other than its employees, subject to limits of liability of not less than $1,000,000 each occurrence and, when applicable, $2,000,000 annual aggregate, for non-automobile hazards and as required by law for automobile hazards. [*MIChild* I-P.3]

d. Claims for damages because of injury to or destruction of tangible property, including loss of use resulting therefrom, subject to a limit of liability of not less than $50,000 each occurrence for non-automobile hazards and as required by law for automobile hazards. [*MIChild* I-P.4]

e. Insurance for subparagraphs (c) and (d) non-automobile hazards on a combined single limit of liability basis shall not be less than $1,000,000 each occurrence and, when applicable, $2,000,000 annual aggregate. [*MIChild* I-P.5]

f. The insurance noted in this section shall be written for not less than any limits of liability herein specified or required by law, whichever is greater. [*MIChild* I-P.8]

3. Minority Owned Business. Provider/Subcontractor shall not discriminate against minority-owned and women-owned businesses and businesses owned by persons with disabilities in any subcontracting. Any such discrimination will be a material breach of contract. [*MIChild* I-U.2]

4. Conduct of Personnel. The Subcontractor shall notify the Company if Subcontractor, or any of its subcontractors, officers, directors, or key personnel have ever been convicted of a felony, or any crime involving moral turpitude, including but not limited to fraud, misappropriation, or deception. Subcontractor shall promptly notify Company of any criminal litigation, investigations, or proceedings that have arisen or may arise involving the Subcontractor or any of the Subcontractor's subcontractors, or any of the foregoing entities' then-current officers or directors during the term of the *MIChild* Contract and three years thereafter. [*MIChild* I-DD.1]

5. Litigation. Subcontractor shall notify Company, as promptly as possible, of any civil litigation, arbitration, proceedings, or judgments that have arisen or may arise against it or its subcontractors during the term of the *MIChild* Contract or within three years thereafter, that involve (1) products or services similar to those provided to the State under the *MIChild* Contract and that either involve a claim in excess of $250,000 or that otherwise may affect the viability or financial stability of the Subcontractor, (2) a claim or written allegation of fraud against the Subcontractor or its subcontractors hereunder, arising out of their business activities, or (3) a claim or written allegation that the Subcontractor or its subcontractors hereunder violated any federal, state, or local statute, regulation, or ordinance. In addition, multiple lawsuits and/or judgments against the Subcontractor or its subcontractors in an amount less than $250,000 shall be disclosed to Company to the extent they affect the financial solvency and integrity of the Subcontractor or its subcontractors. Subcontractor must cooperate with Company to provide to the State all reasonable assurances requested by the State to demonstrate that: (a) Subcontractor or its subcontractors hereunder will be able to continue to perform under the *MIChild* Contract in accordance with its terms and conditions, or (b) the Subcontractor or its subcontractors will not engage in conduct in performing services under under the *MIChild* Contract that is similar in nature to the conduct alleged in any such litigation, arbitration, or other proceedings. [*MIChild* I-DD]

6. Record Retention and Examination. Subcontractor shall maintain all pertinent financial and accounting records and evidence pertaining to the Agreement and the *MIChild* Contract in accordance with generally accepted principles of accounting and other procedures specified by the State. Subcontractor shall permit the State or the U.S. Department of Health and Human Services or any of their identified agents aceess to the Subcontractor's facilities being utilized at any reasonable time, during normal business hours, to observe the operation of the program. Furthermore, Subcontractor shall retain all books, records, or other documents relevant to the Agreement and the the *MIChild* Contract for six (6) years after final payment, at its cost, and federal auditors and any persons duly authorized by the State shall have full access to and the right to examine and audit any of said material during said period. If an audit is initiated prior to the expiration of the six (6)

year period, and extends past that period, all documents shall be maintained until the audit is completed. Subcontractor shall assure, as a condition of any sale or transfer of ownership of Subcontractor, that the new purchaser or owner maintains the above-described books, records, or other documents for any unexpired portion of the six (6) year period after final payment under the Agreement and the the *MIChild* Contract, or Subcontractor shall otherwise maintain said records as the State may direct. Subcontractor shall, if it ceases business operations, maintain the records as the State may direct. [*MIChild* I-I]

7. Provider Care. In the event Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement, or in the event you are a Provider, your Agreement with Company hereby incorporates, and you shall ensure that your contracts with any of your downstream subcontractors or providers incorporate, the requirements set forth above in Subsection B.12 of this Michigan Medicaid/CHIP Addendum, as well as the following additional requirements:

a. Providers shall be responsible for providing primary and specialty care to Enrollees. In addition, primary care providers are responsible for initiating referrals for specialty care and maintaining the Enrollee's medical record, which shall include documentation of all services provided. [*MIChild* II-M.5(a)]

b. Provider/Subcontractor shall ensure that: (i) Enrollees will not be denied a covered service or availability of a facility or provider identified in the *MIChild* Contract; and (ii) providers will not intentionally segregate *MIChild* Enrollees in any way from other persons receiving health care services. [*MIChild* II-M.5(b)]

c. Any medical records, required data, reports of services, or reports on complaints, grievances, quality, or utilization issues for Enrollees must be made available to Company. [*MIChild* II-M.5(b)]

d. Providers shall accept the Enrollees along with all other Enrollees of Company, and not segregate them in any way or treat them in a location or manner different from other Enrollees. [*MIChild* II-M.5(b)]

e. To the extent reasonably possible and as applicable, Provider/Subcontractor must require its contracted providers to maintain medical records of all medical services received by the Enrollees and assist with Company's record maintenance/confidentiality/access requirements under the *MIChild* Contract. [*MIChild* II-Y]

Exhibit A.3

Individual Sites Regulatory Compliance Addendum (Michigan)

Governing Medicare-Medicaid Dual-Eligible Services

This Regulatory Compliance Addendum Governing Medicare-Medicaid Dual-Eligible Services (the "Duals Addendum") shall govern the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the *Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services, In Partnership with the State of Michigan and Aetna Better Health of Michigan Inc.*, issued on September 25, 2014 (the "Three-Way Contract"), which established and governs the program known as the MI Health Link Duals Demonstration (the "Demonstration"), under which Aetna Better Health of Michigan Inc. ("Company") serves as an "Integrated Care Organization," and as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and/or the Demonstration.

This Duals Addendum is incorporated by reference into the Agreement between Company and the provider, vendor, contractor, or other entity executing the Agreement, as identified on the first page of the Agreement (the "Provider"), and Provider must comply with the requirements set forth herein. Note that this Duals Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement, in the Three-Way Contract, and in Company's policies, procedures, and provider manual. This Duals Addendum and the Agreement may be revised as directed by the State of Michigan and/or by the Centers for Medicare and Medicaid Services.

For purposes of this Duals Addendum, Company may be referred to as "ICO" or "MCO" (a/k/a integrated care organization and managed care organization, respectively), and the individuals who are enrolled with Company under the Demonstration may be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Duals Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Duals Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Duals Addendum will govern and control with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and the Demonstration; provided, however, that if there is any conflict between any of the terms of this Agreement, including this Duals Addendum, and the Three-Way Contract, then the terms of the Three-Way Contract will govern and control. Except as provided herein, all other provisions of the Agreement not inconsistent with this Duals Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Duals Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Three-Way Contract and the remainder of the Agreement.

Provider acknowledges and agrees that all provisions of this Duals Addendum shall apply equally to any employees, independent contractors, subcontractors, downstream entities, or related entities of Provider that provide Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, or that provide administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and the Demonstration, and Provider represents and warrants that Provider shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Duals Addendum and all applicable laws and regulations.

REQUIREMENTS FOR THE DEMONSTRATION

A. Michigan State Requirements

The State of Michigan and/or the Michigan Department of Health and Human Services ("MDHHS") requires that specific terms and conditions be incorporated into the Agreement because the Agreement is a contract between a health maintenance organization and a provider. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the following requirements with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract and the Demonstration:

1. Provider shall look only to MCO for compensation for services rendered to an Enrollee when such services are covered by the Plan. Provider agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against an Enrollee or person acting on behalf of an Enrollee (other than MCO), except to the extent that copayments, coinsurances, and/or deductibles are specified in the Plan or as permitted pursuant to coordination of benefits. (All copayments, coinsurances, and deductibles shall be applied by MCO in accordance with applicable law, including without limitation MCL 500.3515.) Provider agrees not to maintain any action at law or in equity against an Enrollee to collect sums that are owed by MCO to such Provider under the terms of the Agreement, even in the event MCO fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This provision shall survive termination of the Agreement, regardless of the cause of termination and shall be construed to be for the benefit of the Enrollee. This provision is not intended to apply to services provided after this Agreement has been terminated, except as otherwise provided in this Agreement, or to non-Covered Services. Provider further agrees that this provision supersedes any oral or written agreement, hereinafter entered into between such Provider and Enrollee or persons acting on Enrollee's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement. [MI ADC R. 325.6345(2); MI Ins. Code 500.3529(3)]

2. Provider shall meet applicable licensure or certification requirements. [MI ADC R. 325.6345(3)(a); MI Ins. Code 500.3529(4)(a)]

3. Provider shall allow appropriate access to records or reports concerning services to Enrollees. [MI ADC R. 325. 6345(3)(b); MI Ins. Code 500.3529(4)(b)]

4. Provider shall cooperate with MCO's quality assurance activities. [MI ADC R. 325. 6345(3)(c); MI Ins. Code 500.3529(4)(c)]

5. In the event of MCO's insolvency, Provider shall continue to provide services to Enrollees. MCO acknowledges that it is required by law to provide a mechanism for appropriate sharing of the continuation of Provider services as approved by the Michigan Insurance Commissioner and in no event shall such continuation be solely the responsibility of Provider. [MI Ins. Code 500.3561]

6. The definition of Clean Claim that is set forth in the Agreement shall additionally include the applicable Michigan statutory requirements set forth in MCL 400.111*i*(2)(a). Company shall pay all Clean Claims in accordance with the terms and requirements set forth in MCL 400.111*i*.

7. Notwithstanding anything to the contrary in the Agreement, the laws of the State of Michigan shall govern the Agreement as it relates to Company (namely, Aetna Better Health of Michigan Inc.) and to all Covered Services that Provider provides to Company's Members, regardless of where Provider is located, unless Michigan law is preempted by federal law consistent with Section 5.1.13.2 of the Three-Way Contract.

B. Medicare Requirements

Without limiting any obligation of Provider under the Agreement, Provider shall comply with, and shall cause its Downstream Entities and Related Entities to comply with, the requirements set forth in this **Section B** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider), as applicable, that relate to those Covered Services or to the Three-Way Contract and the Demonstration (the "Medicare Services"). (The terms "Downstream Entities" and "Related Entities" shall have the respective meanings that are ascribed to them in **Schedule 1** hereto, and shall include Provider's permanent and temporary employees.) For purposes of this **Section B**, the Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration shall collectively be referred to as the "Medicare Members," and the managed-care plan that MCO offers under the Three-Way Contract and the Demonstration shall be referred to as the "Medicare Plan." Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. 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 Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement).

B. MCO shall not pay any amounts beyond the amounts set forth in the applicable Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement), 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 MCO 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, MCO's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. MCO 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 adjust payments to Provider for Covered Services until the earlier of (i) the discontinuation of the Medicare Payment Adjustment, or (ii) the replacement of the Medicare Payment Adjustment by a subsequent Medicare Payment Adjustment.

C. Pursuant to Section B.5.K. of this Duals Addendum, Provider certifies that the diagnosis codes submitted to MCO for Medicare Members that MCO is required to submit to CMS will be accurate, complete, and truthful (the "Certification"). Provider acknowledges and agrees that MCO may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to MCO 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, "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 (the "Medicare Statute of Limitations"). If MCO makes an overpayment or payment in error to Provider for Medicare Members, MCO 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 MCO's reasonable suspicion of fraud or other intentional misconduct.

E. In no event, including without limitation non-payment by MCO, insolvency of MCO, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Medicare Member or persons (other than MCO) acting on a Medicare Member's behalf for services covered under the Agreement. Provider further agrees that: (i) this provision shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Medicare Members, and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Medicare Member or persons acting on a Medicare Member's behalf. No modification of this provision shall be effective without the prior written approval of the appropriate regulatory entities.

2. ASSIGNMENT. In addition to all other rights of MCO under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Duals Addendum) may be assigned by MCO, at any time and from time to time, in whole or in part, to any other affiliate or successor in interest of MCO. At MCO's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with MCO for those products/lines of business designated by MCO 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, MCO shall provide advance written notice to Provider. In the event of a conflict between this Section and any other provision of the Agreement, the terms of this Section shall supersede and prevail.

3. EFFECT OF TERMINATION. In the event this Duals Addendum is terminated for any reason, such termination shall not constitute termination of any of MCO's other products, plans, or programs.

4. MEDICARE REQUIRED PROVISIONS. Provider agrees to comply with all of the provisions of the Schedules attached hereto and incorporated into this Duals Addendum (including **Schedule 1** and any delegated function-specific Schedules that may be appended hereto), and agrees that all terms and conditions in the Agreement applicable to Provider shall also apply to any Downstream Entities of Provider. Provider further acknowledges and agrees that all terms of such Schedules shall apply equally to services provided in connection with the Three-Way Contract and the Demonstration, even if such Schedules only refer to Medicare Advantage products. Provider acknowledges that to the extent MCO is delegating to Provider any activities and responsibilities in connection with the Three-Way Contract and the Demonstration, MCO may only delegate such activities and responsibilities in a manner consistent with the contractual and legal obligations and duties imposed on MCO under the Three-Way Contract and under applicable Medicare laws, regulations, rules, and other directions of CMS.

5. 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. Compliance; Cooperation. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement will be consistent and comply with MCO's obligations under the Three-Way Contract. Upon request, Provider shall immediately provide to MCO any information that is required by MCO 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 MCO that MCO, 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 MCO 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 MCO for the Medicare Plan from CMS pursuant to the Three-Way Contract, as well as payments that Provider receives from MCO for performing services and functions under the Agreement, constitutes the receipt of federal funds. As a result, Provider, by entering into this Agreement and the terms of this Duals 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 the Three-Way Contract terminates or MCO becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized 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 Duals Addendum, regardless of the reason for termination, including the insolvency of MCO, and shall supersede any oral or written agreement between Provider and a Medicare Member.

E. Policies, Programs & Procedures. Provider agrees to comply with MCO's policies and procedures (which MCO shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Duals Addendum, and the Three-Way Contract and Demonstration. Provider agrees to comply with MCO's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies MCO may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that an MCO 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, on behalf of itself and its Downstream Entities (if any), shall preserve records applicable to Medicare Members or to MCO's participation in the Three-Way Contract and Demonstration, 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 42 C.F.R. § 423.2480(c) and to maintain all records containing data used by MCO to calculate Medicare medical loss ratios ("MLRs") for MCO's Medicare products and/or evidence needed by MCO 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 MCO to CMS. Provider further agrees that with respect to Medicare Plans, MCO and federal governmental authorities having jurisdiction, and their designees, upon request, shall have access to all MLR Records, and that this right of inspection, evaluation, and audit of MLR Records shall continue for a minimum of ten (10) years from the date such MLRs were reported by MCO to CMS. This provision shall survive the termination of the Agreement, regardless of the cause of termination.

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 (a) all of the contractual and legal obligations and duties imposed on Provider in the Agreement, (b) all provisions required under Medicare laws, regulations, rules, and other directions of CMS (including all of MCO's obligations under such laws, regulations, rules, and other directions related to the scope of Provider's services under the Agreement), and (c) that any delegated services or activities to be performed by subcontractor shall be consistent and comply with the obligations in the Three-Way Contract. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly. Provider acknowledges that, with respect to any services or functions under the Agreement that Provider delegates to a subcontractor, such subcontractor shall be considered a Downstream Entity.

(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 MCO delegates to Provider the selection of providers, MCO retains the right to approve, suspend or terminate such delegation. If MCO delegates the selection of providers, MCO will either review the credentials of medical professionals affiliated with Provider or MCO 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 and/or 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 shall not employ or contract with, with or without compensation, any individual or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in a federal health care program. 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. Furthermore, neither Provider nor any of Provider's Downstream Entities who are and/or will be fully or partially responsible for Provider's performance of its obligations under the Agreement has (i) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; (ii) been excluded from participation in any federal or state funded health program; or (iii) been listed in the Department of Health and Human Services Office of Inspector ("OIG") exclusion list or the General Services Administrative ("GSA") exclusion list. Provider agrees to immediately notify MCO in the event that Provider or any of its Downstream Entities that assist or are involved in Provider's performance of services for Medicare Plans under the Agreement are or become disbarred, excluded, suspended, or otherwise determined to be ineligible to participate in a federal health care program. 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, the "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 the Medicare Plan, 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 Duals Addendum, MCO shall have the right, in its sole discretion and judgment, to terminate this Duals 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 (an "Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative, or other individual or entity) to perform any services for the Medicare Plan 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 MCO, in its sole discretion and judgment, agrees in advance and in writing to the use of

such Offshore Entity. Provider further agrees that MCO has the right to audit any Offshore Entity prior to the provision of Offshore Services for the Medicare Plan. Provider further represents and warrants that it does not and will not permit any Medicaid Members' protected health information (PHI) or other personal information to be accessible by any Offshore Entity, without prior written notice to MCO and MCO's prior written approval of such Offshore Entity. In the event that MCO agrees in advance and in writing to permit Provider to use an Offshore Entity to perform any services for Medicare Plans and MCO agrees that such Offshore Entity will receive, process, transfer, handle, store, or access Medicare Member PHI as defined at 45 C.F.R. § 160.103, Provider agrees that Offshore Services that involve Medicare Member 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 MCO 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 MCO and to provide MCO with all such information in such form and manner as requested by MCO. Provider agrees to immediately notify MCO if any encounter data that Provider submitted to MCO for Medicare Members is inaccurate, incomplete, or erroneous, and to cooperate with MCO to correct erroneous encounter data to ensure MCO's compliance with Medicare laws, rules and regulations and CMS instructions.

K. Certification of Data. Provider recognizes that MCO 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 MCO by its contractors and subcontractors. Provider and its subcontractors, if any, hereby certify that any such data submitted to MCO will be accurate, complete, and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by MCO.

L. Medicare Member Complaints. Provider agrees to cooperate with MCO in resolving any Medicare Member complaints related to coverage or the provision of Covered Services. MCO 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 MCO 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 Downstream Entities, if any, 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 the Medicare Plan. Such compliance program shall be appropriate to the organization and operations of Provider and Provider's Downstream Entities and shall include:

(1) written compliance policies and standards of conduct that are comparable to Aetna's compliance policies/Aetna Code of Conduct and articulate the entity's commitment to comply with federal and state laws, ethical behavior, and compliance program operations. Provider will disseminate either Aetna's compliance policies/Aetna Code of Conduct or comparable versions to Provider's employees, officers, and Downstream Entities within 90 days of hire/contracting, when updates are made, and annually thereafter;

(2) reporting mechanisms communicated to Provider's employees and Downstream Entities for their use in adhering to the expectation that Provider, its employees, and its Downstream Entities report potential non-compliance or FWA issues (internally and to Company, as applicable) and understand their obligation to report. Provider must publicize the reporting methods to Provider employees and Downstream Entities along with a no-tolerance policy for retaliation or retribution for good-faith reporting;

(3) completion of CMS's Medicare Learning Network® (MLN) "Medicare Parts C

and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training" by Provider employees, officers, and Downstream Entities initially within ninety (90) days of hire/contracting and at least annually thereafter, unless exempt from such training under relevant CMS regulations;

(4) processes to oversee and ensure that Provider and Provider's Downstream Entities maintain compliance with processes to oversee and ensure that: (1) Provider and Provider's Downstream Entities maintain compliance with CMS compliance program requirements, and (2) Provider's Downstream Entities perform Medicare Services consistent with this Agreement and the agreement between Provider and such Downstream Entities. Provider's oversight under this Agreement shall include: (1) imposition of disciplinary actions, as needed, to ensure employee compliance with CMS compliance program requirements, and (2) implementation of corrective actions (up to and including contract termination), as needed, with respect to its Downstream Entities to ensure Downstream Entity compliance with applicable CMS requirements, including the CMS compliance program requirements, this Agreement, and Provider's contract with the Downstream Entity;

(5) retention of evidence showing that Provider and Provider's Downstream Entities complied with the requirements set forth in this Section. Such evidence must be maintained for at least the period of time specified in Section B.5.F. hereof and shall be made available to Company and CMS, upon request.

N. Marketing. Consistent with federal laws, regulations, and agency requirements applicable to the Medicare program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare Members, 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 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 it will not collect Cost Sharing Amounts from Medicare Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the MCO'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.

P. Enrollment as Medicare Provider. To the extent that Provider prescribes drugs covered under Medicare Part D to Medicare Members who have Medicare prescription drug ("MA-PD") coverage offered by MCO, Provider agrees to comply with the requirements set forth in 42 C.F.R. § 423.120(c)(6), including without limitation the requirement that Provider be enrolled in Medicare in an approved status in order for its prescriptions to be covered under Medicare Part D.

Q. Home Infusion Drugs. The following provisions shall only apply to Provider if Provider dispenses to a Medicare Member home infusion drugs that are covered under Medicare Part D and the Medicare Member has MA-PD coverage offered by MCO ("Home Infusion Drug"):

1. With respect to Home Infusion Drugs, MCO will pay clean claims (as defined in 42 C.F.R. § 423.520(b)) submitted by Provider on behalf of Medicare Members within 14 days for electronic claims and within 30 days for claims submitted otherwise. 42 C.F.R. § 423.505(i)(3)(vi).

2. Home Infusion Drugs will be reimbursed (as applicable) in accordance with a fee schedule, or the third-party pricing source (*e.g.*, Medi-Span) otherwise agreed upon as set forth in this Agreement or Provider's agreement with MCO's Pharmacy Benefit Manager ("PBM"). 42 C.F.R. § 423.505(i)(3)(viii)(B).

3. If a prescription drug pricing standard is used for reimbursement of Home Infusion Drugs, updates to such a standard will occur not less frequently than once every 7 days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the Home Infusion Drug. 42 CFR § 423.505(i)(3)(viii)(A).

4. In accordance 42 C.F.R.§ 423.120(c)(3), Provider agrees to submit claims for Home Infusion Drugs to MCO or its PBM whenever the Medicare Member's ID card is presented or is on file at the Provider, unless the Medicare Member expressly requests that the claim not be submitted to MCO or its PBM.

5. Provider must submit claims for Home Infusion Drugs in real time by means of point of service claims adjudication systems in compliance with CMS standards. 42 C.F.R. § 423.505(b)(17).

6. Provider must provide Medicare Members with access to the negotiated prices (as defined in 42 C.F.R. § 423.100) for Home Infusion Drugs to Members. 42 C.F.R. § 423.104(g)(1).

7. Provider must charge/apply the correct cost-sharing amount to the Medicare Member for Home Infusion Drugs. 42 C.F.R. § 423.104.

8. At the time of purchase by a Medicare Member, Provider must inform the Medicare Member of any differential between the price of the Home Infusion Drug being dispensed and the price of the lowest priced generic version of that Home Infusion Drug available from Provider, unless the Home Infusion Drug being dispensed is the lowest priced generic version of that Home Infusion Drug. 42 C.F.R. § 423.132.

9. Provider agrees to ensure that the professional services and ancillary supplies necessary for Home Infusion Drugs are in place before dispensing Home Infusion Drugs to a Medicare Member in his/her place of residence. 42 C.F.R. § 423.120(a)(4)(iii).

10. Provider agrees to provide delivery of Home Infusion Drugs within 24 hours of a Medicare Member's discharge from an acute setting, or later if so prescribed. 42 C.F.R. § 423.120(a)(4)(iv).

11. Provider shall submit to MCO (not PBM) claims for equipment, supplies, and professional services associated with Home Infusion Drugs dispensed by Provider to a Medicare Member that are covered under Medicare Part C.

R. Non-Covered Services. Provider shall not hold a Member financially responsible for payment of a service not covered under the Member's Plan ("Non-Covered Service") unless the Member has received a pre-service organization determination notice of denial from Company before such services are rendered. Provider acknowledges and agrees that if Provider renders Non-Covered Services to a Member who has not received a pre-service organization determination notice of denial from Company, the Provider must hold the Member harmless for the Non-Covered Services and cannot charge the Member any amount beyond the normal cost-sharing amounts (*i.e.*, copayments, coinsurance, and/or deductibles). With respect to those Non-Covered Services that are clearly listed as exclusions in the Member's Evidence of Coverage or other similar Plan document, a pre-service organization determination is not required in order for Provider to hold the Member financially liable for such Non-Covered Services.

6. COMPANY OBLIGATIONS.

A. Fee Schedule. MCO shall arrange for Provider to be compensated for health care services rendered to Medicare Members in accordance with Section B.1 of this Duals Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(a)(1), MCO 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 Duals Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. § 422.500.

C. From time to time MCO may designate only certain Providers to take part in the provider delivery network for a particular product benefit plan(s).

7. GENERAL PROVISIONS.

A. Termination. This Duals 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 and the Three-Way Contract. This Duals Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement and the Three-Way Contract.

B. Governing Law. This Duals Addendum shall be governed by federal laws, regulations, and agency requirements applicable to the Medicare program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare program occur, the new law, regulation, or agency requirement shall supersede to the extent required by any such later required changes.

C. Agreement Otherwise Unmodified. 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 Duals Addendum and the Agreement, the terms of this Duals Addendum shall govern and control.

D. Survival. All provisions of this Duals Addendum that 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.

C. Requirements Under the Demonstration Three-Way Contract

The Three-Way Contract requires that specific additional terms and conditions be incorporated into the Agreement. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the requirements set forth in this **Section C** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract and the Demonstration. With respect to the requirements set forth in this **Section C**, any capitalized terms that are used but not defined herein shall have the meanings that are ascribed to them in the Three-Way Contract. Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. The delegated activities and reporting requirements for which Provider is responsible are contained in the Agreement. Provider shall ensure that it and its downstream and related entities perform all such delegated activities and reporting requirements in compliance with 42 C.F.R. §§ 422.504, 423.505, 438.6(l), and 438.230(b)(1), as applicable. [Appendix C.1 of Three-Way Contract]

2. HHS, the Comptroller General, MDHHS, MDHHS's office of Inspector General, the Medicaid Fraud Control Unit of the Michigan State Police, the Michigan Auditor General, and their designees, and other state and federal agencies with monitoring authority related to Medicare and Medicaid, have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation, of Provider and its downstream and related entities, and the foregoing rights to inspect, evaluate, and audit any pertinent information for any particular contract period shall exist for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later. [Appendix C.2 of Three-Way Contract]

3. Provider and its downstream and related entities shall not hold Enrollees liable for payment of any fees that are the obligation of MCO. [Appendix C.3.1 of Three-Way Contract]

4. Any services or other activity performed by Provider and/or its downstream and related entities shall he performed in accordance with the MCO's contractual obligations to CMS and MDHHS. [Appendix C.3.2 of Three-Way Contract]

5. MCO shall revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS, the MDHHS, or the MCO determine that Provider and/or its downstream and related entities have not performed their delegated activities or reporting requirements satisfactorily. [Appendix C.3.4 of Three-Way Contract]

6. The performance of Provider and its downstream and related entities under the Agreement will be monitored by MCO on an ongoing basis and MCO may impose corrective action as necessary. [Appendix C.3.5 of Three-Way Contract]

7. Provider and its downstream and related entities agree to safeguard Enrollee privacy and confidentiality of Enrollee health records. [Appendix C.3.6 of Three-Way Contract]

8. Provider and its downstream and related entities must comply with all federal and state laws, regulations and CMS instructions. [Appendix C.3.7 of Three-Way Contract]

9. To the extent that Provider and/or its downstream and related entities provide credentialing of medical providers under the Agreement:

   A. The credentials of medical professionals affiliated with the Provider and/or its downstream and related entities will be reviewed by MCO; or

   B. The credentialing process will be reviewed and approved by MCO and MCO shall audit the credentialing process on an ongoing basis.

   [Appendix C.4 of Three-Way Contract]

10. To the extent that MCO has delegated the selection of providers under the Agreement to Provider or its downstream and related entities, MCO retains the right to approve, suspend, or terminate that arrangement. [Appendix C.5 of Three-Way Contract]

11. Unless otherwise permitted under the Three-Way Contract or by the consent of CMS and MDHHS, neither MCO nor Provider has the right to terminate the Agreement without cause, and Provider shall provide at least 60 calendar days' notice to MCO and assist with transitioning Enrollees to new providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the MCO or Enrollee. [Appendix C.6 of Three-Way Contract]

12. MCO shall provide a written statement to Provider of the reason or reasons for termination for cause. [Appendix C.7 of Three-Way Contract]

13. MCO is obligated to pay Provider under the terms of the Agreement, which includes a prompt-payment provision that has been developed and agreed to by both MCO and Provider. [Appendix C.8.1 of Three-Way Contract]

14. Provider and its downstream and related entities shall provide all services under the Agreement in a Culturally Competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds. [Appendix C.8.2 of Three-Way Contract]

15. Provider and its downstream and related entities shall abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. [Appendix C.8.3 of Three-Way Contract]

16. Provider and its downstream and related entities shall ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas. [Appendix C.8.4 of Three-Way Contract]

17. Provider and its downstream and related entities shall maintain Enrollee records and information in an accurate and timely manner. [Appendix C.8.5 of Three-Way Contract]

18. Provider and its downstream and related entities shall ensure timely access by Enrollees to the records and information that pertain to them. [Appendix C.8.6 of Three-Way Contract]

19. Provider and its downstream and related entities shall not hold Enrollees liable for Medicare Part A and B cost sharing, and all Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees. [Appendix C.8.7 of Three-Way Contract]

20. Provider and its downstream and related entities shall ensure that their EMTALA obligations are fulfilled as required by law and the Agreement and must not create any conflicts with any hospital actions required to comply with EMTALA. [Appendix C.8.8 of Three-Way Contract]

21. Provider and its downstream and related entities, including without limitation all primary care providers, shall not close or otherwise limit acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees. [Appendix C.8.9 of Three-Way Contract]

22. MCO shall not refuse to contract or pay Provider for the provision of Covered Services solely because Provider has in good faith:

    (a) Communicated with or advocated on behalf of one or more of the prospective, current, or former patients of Provider or its downstream and related entities regarding the provisions, terms, or requirements of the MCO's health benefit plans as they relate to the needs of such patients; or

    (b) Communicated with one or more of the prospective, current, or former patients of Provider or its downstream and related entities with respect to the method by which such provider is compensated by the MCO for services provided to the patient.

    [Appendix C.8.10 of Three-Way Contract]

23. Provider and its downstream and related entities are not required to indemnify MCO for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against MCO based on MCO's management decisions, utilization review provisions, or other policies, guidelines, or actions. [Appendix C.8.11 of Three-Way Contract]

24. Provider and its downstream and related entities shall comply with all MCO's requirements and MCO Policies for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services. [Appendix C.8.12 of Three-Way Contract]

25. MCO shall notify Provider in writing of modifications in payments, modifications in Covered Services, or modifications in MCO's procedures, documents, or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 30 calendar days before the effective date of such modification unless such other date for notice is mutually

agreed upon between MCO and Provider or unless such change is mandated by CMS or MDHHS without 30 calendar days' prior notice. [Appendix C.8.13 of Three-Way Contract]

26. Provider and its downstream and related entities shall not bill Enrollees for charges for Covered Services other than pharmacy co-payments, if applicable. [Appendix C.8.14 of Three-Way Contract]

27. No payment shall be made by MCO to Provider for a Provider Preventable Condition as defined in 42 C.F.R. § 447.26(b). [Appendix C.8.15 of Three-Way Contract]

28. As a condition of payment, Provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by MCO. Provider shall comply with such reporting requirements to the extent Provider directly furnishes services. [Appendix C.8.16 of Three-Way Contract]

29. Provider shall ensure coverage for its practice twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable. [Appendix C.8.17 of Three-Way Contract]

30. MCO shall monitor and ensure that all Utilization Management activities provided by Provider comply with all provisions of the Three-Way Contract with CMS and MDHHS, and Provider and its downstream and related entities shall cooperate with and utilize MCO's Quality Assurance Program. [Section 2.13.3.1.4.2 of Three-Way Contract]

31. Provider shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. Contracts or arrangements with First Tier, Downstream and Related Entities shall not include incentive plans that include a specific payment to Provider or its downstream and related entities as an inducement to deny, reduce, delay, or limit specific, Medically Necessary Services, and (a) Provider and/or its downstream and related entities shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate, and (b) MCO shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate. Nothing herein shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared-risk agreements that are made with respect to physicians or physician groups or that are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services, and equipment provided or authorized by another physician or health care provider, comply with Paragraph 32 immediately below. [Section 5.1.7.2 and Appendix C.9 and C.11 of Three-Way Contract]

32. MCO shall not impose a financial risk on Provider or its downstream and related entities for the costs of medical care, services or equipment provided or authorized by another Physician or health care provider unless such contract includes specific provisions with respect to the following:

    A. Stop-loss protection;

    B. Minimum patient population size for the Physician or Physician group; and

    C. Identification of the health care services for which the Physician or Physician group is at risk.

    [Appendix C.12 of Three-Way Contract]

33. All contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites that provide services must include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or

waiver of a certificate of registration along with a CLIA identification number. [Appendix C.13 of Three-Way Contract]

34. Nothing shall be construed to restrict or limit the rights of MCO to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious nonmedical providers. [Appendix C.14 of Three-Way Contract]

35. Provider shall meet all terms and requirements of the Three-Way Contract that are applicable to Provider. [Section 2.7.7.1 of Three-Way Contract]

36. Provider and its downstream and related entities shall allow MCO to access the medical records of Enrollees.

37. Provider will collaborate with MCO on documentation systems reporting, communications, policies, and any other matters necessary for any readiness review required under the Three-Way Contract. [Section 2.2.1.3 of Three-Way Contract]

38. Provider must notify MCO within fourteen (14) calendar days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "**Legal Proceedings**") involving Provider or any of its its downstream and related entities, or any officer or director of Provider or any of its its downstream and related entities, that arises during the term of the Agreement, including: any criminal Legal Proceeding; any parole or probation Legal Proceeding; any Legal Proceeding under the Sarbanes-Oxley Act; or any civil Legal Proceeding that involves a claim that might reasonably be expected to adversely affect Provider's viability or financial stability, that involves a governmental or public entity's claim or written allegation of fraud, or that involves a Legal Proceeding involving any license that Provider is required to possess in order to perform under this Agreement or the Three-Way Contract. [Section 2.1.2.1.10 of Three-Way Contract]

39. Provider shall submit to MCO the organizational chart of Provider. [Section 2.2.3.4 of Three-Way Contract]

40. Provider shall collaborate with MCO, as requested and required under the Three-Way Contract, on activities relating to the Care Bridge, the Care Coordination Platform, and the Integrated Care Bridge Record. [Section 2.5 of Three-Way Contract]

41. As requested and required under the Three-Way Contract, Provider shall actively participate as a member of the Integrated Care Team and shall collaborate with the Enrollee and other members of the Integrated Care Team to ensure performance of the following tasks, as may be applicable:

    a. Development, implementation, and revision of the Individual Integrated Care and Supports Plan ("**IICSP**") according to the Person-Centered Planning Process and the Enrollee's stated goals including making whatever accommodations are appropriate for individuals whose disabilities create obstacles to full participation with the ICT.

    b. Participation in the Person-Centered Planning Process at tbe Enrollee's discretion to develop the IICSP.

    c. Collaboration with other ICT members to ensure the Person-Centered Planning Process is maintained.

    d. Assisting the Enrollee in meeting his/her goals.

    e. Monitoring and ensuring that Provider's part of the IICSP is implemented in order to meet the Enrollee's goals.

    f. Updating the ICBR as needed pertinent to the Provider's role on the ICT.

g. Reviewing assessment, test results, and other pertinent information in the ICBR.

h. Addressing transitions of care when a change between care settings occur.

i. Ensuring continuity of care requirements are met.

j. Monitoring for issues related to quality of care and quality of life.

k. Adherence to an Enrollee's determination about the appropriate involvement of his or her medical providers and caregivers, according to HIPAA and, for individuals in substance use disorder treatment, C.F.R. 42, Part 2.

[Section 2.5.2.5 of Three-Way Contract]

42. Provider must maintain physical sites that are accessible to all Enrollees, and must comply with and apply the United States Supreme Court's *Olmstead* decision which requires that Enrollees be served in the most integrated setting appropriate to their needs. [Section 2.7.2.3 of Three-Way Contract]

43. Provider shall be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollee with disabilities (both congenital and acquired disabilities), or other special population served by the MCO. [Section 2.7.2.5 of Three-Way Contract]

44. To the extent that Provider is multilingual, Provider shall understand and comply with its obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Provider to meet these obligations. [Section 2.7.2.6 of Three-Way Contract]

45. Provider shall maintain a strong understanding of disability, recovery, and resilience cultures, and Long Term Supports and Services. [Section 2.7.2.8 of Three-Way Contract]

46. To the extent that Provider provides Medicare-covered services, Provider shall be enrolled as a Medicare provider in order to submit claims for reimbursement or otherwise participate in the Medicare program. To the extent that Provider provides Medicaid-covered services, Provider shall be enrolled in the Michigan Medicaid program, if such enrollment is required by MDHHS's rules or policy, in order to submit claims for reimbursement or otherwise participate in the Michigan Medicaid program. [Section 2.7.2.10 of Three-Way Contract]

47. To the extent applicable, Provider must ensure that nursing facility beds will be held for the Enrollee for hospital and therapeutic leave days pursuant to the Michigan Medicaid Provider Manual/Nursing Facility Coverages/Special Placements and Agreement. [Section 2.7.2.11 of Three-Way Contract]

48. Provider and its facilities must be appropriately licensed or certified, as applicable, if required pursuant to the Michigan Public Health Code, 1978 PA 368, as amended, MCL 333.1101-333.25211. [Section 2.7.2.12 of Three-Way Contract]

49. Provider shall notify MCO immediately if Provider has lost any required license or state or federal approval, or been excluded from participation in federal health care programs by the OIG of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 *et seq.*, or has been terminated from participation under Medicare, the Michigan Medicaid program, or another state's Medicaid program, except as permitted under 42 C.F.R.§ 1001.1801 and § 1001.1901. [Sections 2.7.3.5.1 and 5.3.4 of Three-Way Contract]

50. If Provider is a Primary Care Provider, Provider must be available to see patients a minimum of twenty (20) hours per week per practice location, as per state Medicaid policy. [Section 2.7.3.6.4 of Three-Way Contract]

51. Provider shall comply with and meet all applicable MCO standards for licensure, certification, and credentialing. [Section 2.7.3.11.4 and 2.7.3.11.5 of Three-Way Contract]

52. Provider shall not engage in any practice with respect to any Enrollee that constitutes unlawful discrimination under any state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90. [Section 2.7.3.11.6 of Three-Way Contract]

53. As requested by MCO, Provider shall submit disclosures in accordance with 42 C.F.R. § 455 Subpart B and 42 C.F.R. § 1002.3. [Section 2.7.3.11.7 of Three-Way Contract]

54. Provider may not seek payment for a Provider Preventable Condition, and Provider shall, as a condition of payment from MCO, comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by MCO and/or MDHHS. [Section 2.7.4.7.3 of Three-Way Contract]

55. Provider shall comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal-related healthcare programs, including Medicare, Medicaid, and/or Children's Health Insurance Program, and shall upon MCO's request provide all required disclosures in accordance with 42 C.F.R. § 455, 42 C.F.R. § 1002.3, and otherwise. [Section 2.7.5.8 and 5.1.6 of Three-Way Contract]

56. To the extent applicable, Provider must (a) afford Enrollees the opportunity and assistance with filing a Grievance, Appeal, or State Fair Hearing, and must permit an Enrollee to request continuation of benefits if the Enrollee files an Appeal or a request for a State Fair Hearing within specified timeframes, (b) use the the existing Part D Appeals Process, and (c) remain compliant with all state and federal laws, regulations, and policies governing the Appeal and State Fair Hearing processes, and all statutory and regulatory timelines related thereto, including the requirements for both standard and expedited requests. If any Grievance or Appeal is filed with Provider, Provider must immediately forward it to MCO. [Section 2.7.7.4 and 2.10.1.1 of Three-Way Contract]

57. Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees. [Section 2.8.1.5 of Three-Way Contract]

58. Provider must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) as outlined in the Three-Way Contract, and must maintain capacity to deliver services in a manner that accommodates the needs of Enrollees. [Section 2.8.1.6 and 2.8.12 of Three-Way Contract]

59. Upon MCO's request, Providers must provide the following information: (a) its name, address, and telephone number; (b) its areas of special experience, skills, and training, including any expertise in treating persons with physical disabilities, chronic illness, HIV/AIDS, or persons with serious mental illness; persons who are homeless; persons who are deaf, hard-of-hearing, blind, and/or visually impaired; or persons with co-occurring disorders; (c) its office hours, including the name of any provider site open after 5:00 p.m. (Eastern Time) on weekdays and/or open on weekends; (d) its cultural and linguistic capabilities, including languages spoken by the Provider or by any skilled medical interpreter at the Provider's site; (e) Provider licensing information; (f) whether it is accessible for people with physical disabilities; (g) whether it is accepting new patients; (h) whether it is accessable by public transportation; and (h) auy languages other than English spoken by Provider or by skilled medical interpreters at Provider's site, and whether translation services are available. [Section 2.14.5.2.1 of Three-Way Contract]

60. As requested and required, Provider must provide any information that CMS and/or MDHHS require (a) under the Three-Way Contract related to the performance of MCO's responsibilities, including non-medical information for the purposes of research and evaluation; (b) to comply with all applicable federal or state laws and regulations; and (c) for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Grievances and Appeals, and enrollment/disenrollment rates. [Section 2.16.1.1 of Three-Way Contract]

61. Collaborate with MCO in the collection and maintenance of all Encounter Data for all Covered Services that Provider provides to Enrollees, ensuring that all such data can be linked to MDHHS eligibility data. [Section 2.17.1.4 of Three-Way Contract]

62. In connection with the Demonstration, Provider shall act in an independent capacity and not as an officer or employee of the federal government, MDHHS, or their respective authorized agents. [Section 5.1.3.1 of Three-Way Contract]

63. Provider may not require any co-payments or other cost-sharing arrangements from Enrollees. Provider must not bill Enrollees for the difference between the Provider's charge and the MCO's payment for Covered Services. Provider must not seek or accept additional or supplemental payment from the Enrollee, his or her family, or representatives, in addition to the amount paid by the MCO even when the Enrollee signed an agreement to do so. [Section 5.1.9.4 of Three-Way Contract]

64. Provider shall not have any interest that will conflict, as determined by CMS and MDHHS with the performance MCO's services under the Three-Way Contract, or that may be otherwise anticompetitive, including without limitation any financial, legal, contractual, or other business interest in any entity performing enrollment functions for MDHHS. [Section 5.3.17.1 of Three-Way Contract]

65. Provider shall conduct all activities in accordance with the Enrollee rights and protections set forth under 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and Appendix B ("Enrollee Rights") of the Three-Way Contract. [Appendix B of Three-Way Contract]

66. Provider may not reuse or provide other entities access to the CMS information system, or data obtained from the system or the State of Michigan, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the MCO contracted with CMS and the State of Michigan. [Appendix G of Three-Way Contract]

Exhibit A.3—Schedule 1

Individual Sites Regulatory Compliance Addendum (Michigan)

Governing Medicare-Medicaid Dual-Eligible Services

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 Amendment 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. **Required Provisions:**

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)]

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:

(i) The delegated activities and reporting responsibilities are specified as follows:

See the Radiology Management Services Agreement, and in particular Exhibit 1 (Description of Delegated Entity Services) and Exhibit 1A (Musculoskeletal Pain Management Services Addendum) thereto

(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.

See the terms of the Radiology Management Services Agreement for specific performance-monitoring provisions.

(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.

N/A—no credentialing functions delegated.

(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.

Exhibit A.4

Individual Sites Regulatory Compliance Addendum (Kentucky)

PROGRAM PARTICIPATION SCHEDULE

Delegated Entity agrees to participate in the Plans and other health benefit programs listed herein:

- ■ Those Medicaid and CHIP (Children's Health Insurance Program) Plans and programs offered by Company within the Commonwealth of Kentucky

Exhibit A.5

Individual Sites Regulatory Compliance Addendum (Kentucky)

Governing Kentucky Medicaid Services

This Regulatory Compliance Addendum Governing Kentucky Medicaid Services (the "Kentucky Medicaid Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under the *Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Coventry Health and Life Insurance Company* (the "State Contract"), under which contract Coventry Health and Life Insurance Company or its successor in interest (the "Company") serves as a managed-care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract.

The Commonwealth of Kentucky, its Finance and Administration Cabinet, its Cabinet for Health and Family Services, and/or its Department for Medicaid Services (collectively, the "State"), require that specific terms and conditions be incorporated into the Agreement. As such, this Kentucky Medicaid Addendum is incorporated by reference into the Agreement between Company and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof), and such provider, vendor, contractor, or other entity must comply with the requirements set forth herein. Note that this Kentucky Medicaid Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in Company's policies, procedures, and provider manual. This Kentucky Medicaid Addendum and the Agreement may be revised as directed by the State.

For purposes of this Kentucky Medicaid Addendum, the individuals who are enrolled with Company under the State Contract will be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Kentucky Medicaid Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Kentucky Medicaid Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Kentucky Medicaid Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contract and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract. Except as provided herein, all other provisions of the Agreement not inconsistent with this Kentucky Medicaid Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Kentucky Medicaid Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The provider, vendor, contractor, or other entity identified on the first page of the Agreement acknowledges and agrees that all provisions of this Kentucky Medicaid Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members who are eligible and covered under the State Contract, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the State Contract, and it/they represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Kentucky Medicaid Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

E. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this Kentucky Medicaid Addendum:

a. "Medically Necessary" or "Medical Necessity" – Nothwithstanding any definition thereof set forth in the Agreement, the foregoing terms shall mean Covered Services that are medically necessary as defined

under Section 2 of 907 KAR 3:130, and provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. § 1396d(r). [State Contract § 1.0]

b. "Provider" – Any person or entity under contract with Company or Company's contractual agent that provides Covered Services to Members. [State Contract § 1.0]

c. "Subcontract" – Any agreement entered into, directly or indirectly, by Company to provide or arrange for the provision of Covered Services. The term "Subcontract" does not include a policy of insurance or reinsurance purchased by Company or its Subcontractor to limit its specific or aggregate loss with respect to Covered Services provided to Members under the State Contract, so long as Company or its risk-assuming Subcontractor assumes some portion of the underwriting risk for providing health care services to Members. [State Contract § 1.0]

d. "Subcontractor" – Any entity other than a Provider, a physician health organization, or a provider network, with which Company has entered into a written agreement for the purpose of fulfilling an obligation of Company under the State Contract. [State Contract § 1.0]

F. Requirements Applicable to Contracts and Services

1. Provision of Covered Services. Provider agrees to provide Covered Services to Members as set forth in the Agreement, including without limitation the following when such Covered Services are specified in the Agreement:

a. If a Member requires emergency medical services, Provider will provide such services on a twenty-four (24) hour per day, seven (7) day per week basis. Provider will provide urgent care services within 48 hours of request. [907 KAR 17:015, § 2; State Contract §§ 29.7, 33.3]

b. If a Member requires the services of a specialist, Provider will provide such specialty services within thirty (30) days from the referral for routine care or within forty-eight (48) hours from the referral for urgent care. [907 KAR 17:015, § 2; State Contract § 29.7]

c. Provider shall provide Covered Services to Members in accordance with the State Medicaid plan, applicable State regulations, and the relevant policies and procedures applicable to each category of Covered Services. [State Contract § 31.1]

d. Provider shall provide basic, targeted, or intensive case management services as Medically Necessary to foster children who are discharged from a hospital or other residential facility, and shall thereafter participate in appropriate discharge planning that is focused on ensuring that the needed supports and services to meet the Member's behavioral-health and physical-health needs will be provided outside of the hospital or other residential facility. [State Contract § 36.4]

e. If Provider is a PCP, Provider shall perform the PCP functions set forth in Section 28.3 of the State Contract. [State Contract § 28.3]

f. Company shall not require Provider to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. § 438.102. Instead, Company shall have a referral process for situations in which a Provider declines to perform a service for ethical reasons. [State Contract § 28.12]

2. Claims; Payment; Coordination of Benefits.

a. Company shall only accept from Provider the uniform claim forms that have been approved by the State and that have been completed according to State guidelines. Provider acknowledges and agrees that the date of Company's receipt of any Provider claim shall be the date as indicated on its

date stamp on the claim or other notation as appropriate to the medium used to file a claim, and that the date of payment shall be the date of the check or other form of payment. [State Contract §§ 30.1. 30.2]

b. Provider acknowledges and agrees that with respect to any Covered Services provided to Dual Eligible Members (as that term is defined in the State Contract), Company shall pay to Provider the lesser amount of: (1) Company's allowed amount minus the Medicare payment, or (2) the Medicare co-insurance and deductible up to Company's allowed amount. [State Contract § 30.4]

c. Provider/Subcontractor acknowledges and agrees that with respect to any Covered Services, Company shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) that is: (1) furnished by any individual or entity during any period when that individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act; (2) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); (3) furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments; (4) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (5) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Medicaid plan; or (6) for home health care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in section 1861(o)(7) of the Social Security Act. [State Contract § 3.7(A)]

d. Upon request of Provider, Company shall provide or make available to Provider, when contracting or renewing this Agreement with such Provider, the payment or fee schedule or other information sufficient to enable Provider to determine the manner and amount of payments under the Agreement for Provider's services prior to the final execution or renewal of the Agreement, and shall provide any change in such schedules at least ninety (90) days prior to the effective date of any such amendment; provided, however, that Company may make periodic, non-material changes to its payment or fee schedules, such as updates to standard codes and guidelines developed by the American Medical Association or a similar organization, or such as changes required by the State or CMS, without prior written notice. [KRS 304.17A-527(1)(d); KRS 304.17A-577(1)(a); KRS 304.17A-577(2)]

e. In no event shall the State or any Member be liable for the payment of any debt or fulfillment of any obligation of Company, Provider/Subcontractor, or any subcontractor to any Provider/Subcontractor, supplier, out-of-network provider, or any other party, for any reason whatsoever, including the insolvency of Company or any Provider/Subcontractor. Provider/Subcontractor agrees that any contracts that Provider/Subcontractor has with its subcontractors will contain a hold harmless provision and will comply with all provisions of the Agreement. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527; State Contract § 13.2]

f. Provider/Subcontractor shall not directly receive payment or any type of compensation from Members for providing Covered Services. Provider/Subcontractor may not bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or any persons acting on their behalf, for services rendered in accordance with the Agreement. This prohibition applies even if Company becomes insolvent, fails to pay Provider/Subcontractor for services rendered, or otherwise breaches the Agreement. This provision does not prohibit the collection from Members of State-authorized co-pays, co-insurance, or deductibles for providing Covered Services. Member co-pay, co-insurance, or deductible amounts cannot exceed the amounts specified in 907 KAR 1:604. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527; State Contract §§ 11.8, 14.2, and 31.4]

g. Provider/Subcontractor shall not bill a Member for Medically Necessary Covered Services, with the exception of applicable co-pays or other cost sharing requirements provided under the State Contract. If Provider/Subcontractor knowingly and willfully bills a Member for a Medicaid Covered Service, Provider/Subcontractor shall be guilty of a felony and upon conviction may be fined 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 Company becomes insolvent. If a Member agrees, in advance, to pay for a service that is not a Covered Service under the State Contract, Company or Provider/Subcontractor may bill the Member for that service. The standard release form signed by a Member at the time of services does not relieve Company or Provider/Subcontractor from the prohibition against billing a Member in the absence of a knowing assumption of liability for a non-Covered Service. The form or other type of acknowledgement relevant to the Member's liability for non-Covered Services shall specifically state the services or procedures that are not covered by Medicaid. [State Contract § 31.4]

h. If Provider/Subcontractor is involved in coordination-of-benefits collections, Provider/Subcontractor shall report coordination-of-benefits information to Company. Provider/Subcontractor shall not pursue collection from the Member, but rather must pursue collection directly from the third party payer or the provider. Access to Covered Services shall not be restricted due to coordination-of-benefits collection. The State has the right to review all billing histories and other data related to coordination-of-benefits activities for Members. [State Contract § 14.1]

i. Company shall process all health care claims submitted for the provision of Covered Services to Members in accordance with KRS 304.17A-726. [KRS 304.17A-726]

j. Provider/Subcontractor acknowledges and agrees that Company shall not pay a Provider/Subcontractor for any provider-preventable condition that meets the following criteria: (1) is identified in the State Medicaid plan; (2) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (3) has a negative consequence for the Member; (4) is auditable; and (5) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. Provider/Subcontractor shall report all provider-preventable conditions associated with claims for payment or Member treatments for which payment would otherwise be made. [State Contract § 31.7]

k. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state plan or waiver.

l. Company shall not be liable to make any payments for Covered Services for which Provider/Subcontractor fails to follow the preadmission authorization and eligibility verification (for inpatient or outpatient services) procedures set forth in the Agreement, the State Contract, or the Medicaid program. Furthermore, all or a portion of payment due to the Provider/Subcontractor may be denied by Company if such payment is specifically attributable to Provider/Subcontractor's rendering or ordering: (i) services that are not Medically Necessary; (ii) elective hospitalization not authorized by Company; (iii) services provided other than at an authorized level of care; (iv) services that are not Covered Services; or (v) services related to complications from a non-Covered Service. In the event Provider/Subcontractor does not agree with a denial of payment determination made, Provider/Subcontractor may file an appeal in accordance with applicable procedures. [State Contract § 28.9]

3. Any Willing Provider; Provider Application; No Discrimination. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall comply with the "any willing provider" statute as described in 907 KAR 1:672 and KRS 304.17A-270, as amended. Neither Company nor such Subcontractor shall require a Provider to enroll exclusively with its network to provide Covered Services under the State Contract. Nothing in the Agreement shall require or be construed to require a Provider, as a condition of participation in the Medicaid product that is the subject of the State Contract, to participate in any other products offered by Company. Company and Subcontractor (if Subcontractor manages a

network of providers as part of the services it provides to Company under the Agreement) shall comply with the terms and obligations set forth in KRS 304.17A-525, and shall allow all providers who desire to apply for network participation an opportunity to apply at any time during the year or, where Company or such Subcontractor does not conduct open continuous provider enrollment, shall conduct a provider-enrollment period at least annually with the date publicized to providers located in the geographic service area of the plan at least thirty (30) days in advance of such enrollment period. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall not discriminate against providers that serve high-risk populations or that specialize in conditions that require costly treatment, and shall not discriminate against a provider based upon that provider's licensure or certification. If Company or such Subcontractor declines to include a provider within its network, it shall give that affected provider written notice of the reason for its decision. Any option to terminate this Agreement without cause, or to non-renew this Agreement, that Company possesses under the terms thereof shall be subject to the "any willing provider" statute and to Provider's right to reapply for network participation, and Company will consider any such Provider reapplication consistent with the internal standards, policies, and procedures for provider participation that Company has developed in accordance with KRS 304.17A-270 and KRS 304.17A-525. [KRS 304.17A-150; KRS 304.17A-270; KRS 304.17A-525; State Contract § 29.1]

4. Anti-Gag Clause; No Retaliation. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall not limit a Provider's disclosure to a Member, or to another person on the Member's behalf, of any information relating to the Member's medical condition, health status, medical care, or treatment options (regardless of whether benefits for such care are provided under the State Contract), and shall not prohibit Provider from discussing all treatment options with the Member. Provider shall not be penalized, and no agreement with a Provider may be terminated, because Provider discusses Medically Necessary or clinically appropriate care with a Member or another person on the Member's behalf. Other information determined by Provider to be in the Member's best interest may be disclosed by Provider to Member or to another person on Member's behalf. Provider shall not be penalized for discussing with a Member any financial incentives and arrangements between the Provider and Company/Subcontractor, nor shall Company take any punitive action against a Provider that either supports, or requests an expedited resolution of, a Member's appeal. [KRS 304.17A-530; State Contract §§ 28.1, 28.12, 31.1]

5. Provider Grievances. Provider shall submit any grievance against Company on the State-approved provider grievance form. [State Contract § 28.9]

6. Connectivity to KHIE. If Provider is a PCP, Provider shall establish connectivity to the Kentucky Health Information Exchange ("KHIE") within one year of the effective date of this Agreement, or as otherwise determined by the State. If Provider is not a PCP, Company still encourages Provider to establish connectivity to KHIE. [State Contract § 17]

7. HEDIS and Encounter Data. Provider/Subcontractor shall submit all reports and clinical information required by Company, including but not limited to, HEDIS, EPSDT, etc., in such manner and pursuant to such timeframes requested by Company. Notwithstanding anything herein to the contrary, Provider/Subcontractor shall provide all necessary data, including but not limited to encounter and claims data, to Company in a format specified by the State in accordance with 42 C.F.R. § 438, unless otherwise agreed by the parties. Provider/Subcontractor shall report and/or submit all encounter records in an accurate and timely fashion. [State Contract §§ 16.1, 20.2, 33.1]

8. Amendments; Notice of Material Change. Company may unilaterally amend the Agreement to the extent necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards, or licensing guidelines or rules ("Regulatory Amendment"). Company shall give advance written notice to Provider of such Regulatory Amendment and the effective date thereof. With respect to amendments other than Regulatory Amendments, Company shall give advance written notice to any "participating provider" of any "material change" to this Agreement, as those terms are used and defined in KRS 304.17A-578, at least ninety (90) days prior to the effective date of the amendment. If Provider is a "participating provider" as that term is used and defined in KRS 304.17A-578: (i) the material-change notice shall include a description of the material change and a statement that Provider has the option to withdraw from the Agreement prior to the material change becoming effective; and (ii) Provider shall send written notice no later than forty-five (45) days prior to the effective date of the material change if Provider opts to withdraw following notice of a material change; provided, however, if Company has not received

notice of such withdrawal within that forty-five (45) day period, Provider's silence shall constitute acceptance of such amendment. If any change to the Agreement is with respect to an existing prior authorization, precertification, notification, or referral program, or changes to an edit program or specific edits, Company shall provide notice of the change to Provider at least fifteen (15) days prior to the change. [KRS 304.17A-578]

9. Assignment. The Agreement, being intended to secure the services of and be personal to Provider/Subcontractor, shall not be assigned or transferred by Provider/Subcontractor without the prior written consent of Company. Company may assign this Agreement without the consent of Provider/Subcontractor to any Affiliate or any other entity upon thirty (30) days' prior written notice. [State Contract § 6.2(H)]

10. Provider Subcontracts. If otherwise permissible under the Agreement, if Provider enters into a subcontract agreement with another provider to provide its licensed health care services to Members where the subcontracted provider will bill Company or Members directly for the subcontracted services, the subcontract agreement must meet all requirements of Ky. Rev. Stat. Chapter 304.17A and shall be filed with the Commissioner of the Kentucky Department of Insurance in accordance with Ky. Rev. Stat. § 304.17A-527(1)(e). [KRS 304.17A-527(1)(e)]

11. State Contract Creates No Third-Party Rights. Provider/Subcontractor acknowledges that the State Contract does not, and is not intended to, create any rights, benefits, or interests to Provider/Subcontractor. [State Contract § 4.5]

12. Subcontracts. With respect to any and all Subcontracts:

a. Subcontractor shall indemnify, defend, and hold harmless the State, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with the State Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor. [State Contract § 6.1]

b. Subcontractor, in the performance of its obligations, shall use only Medicaid-enrolled providers in accordance with the Agreement and the State Contract. [State Contract § 6.2(D)]

c. Subcontractor is prohibited from receiving any incentive, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services. In addition, a Subcontractor that performs utilization management activities is prohibited from receiving, and from providing to any individual or entity that performs such utilization management activities, any incentives for the denial, limit, or discontinuance of Medically Necessary Covered Services to a Member, all consistent with 42 C.F.R. §§ 422.208 and 438.6(h). [State Contract §§ 6.2(G), 21.2, 29.7]

d. Subcontractor is prohibited from assigning the Agreement or from further subcontracting without the prior written consent of the State. [State Contract § 6.2(H)]

e. The State is the intended third-party beneficiary of this Agreement and, as such, the State is entitled to all remedies that are afforded to third-party beneficiaries under the law. [State Contract § 6.2(I)]

f. Subcontractor, as required, shall timely submit encounter records in the format specified by the State so the Company can meet the specifications required by the State Contract. Subcontractor shall be responsible for transmitting all data to Company as required by 42 C.F.R. § 438. [State Contract §§ 6.2(J), 15.1]

g. Subcontractor shall comply with all provisions of the State Contract that relate to the services or activities that Company has delegated to Subcontractor under the Agreement, and Subcontractor shall furthermore comply with all applicable federal and State law and regulations, including but not limited to KRS 205.8451 through KRS 205.8483, all rules, policies, and procedures of the State, and all standards governing the provision of Covered Services and information to Members, all Quality Assessment/Performance Improvement (QAPI) requirements, all record keeping and reporting

requirements, all obligations to maintain the confidentiality of information, all rights of the State, the Office of Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and State agents to inspect, investigate, monitor, and audit operations, all indemnification and insurance requirements, and all obligations upon termination. [State Contract § 6.2(K)]

h. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor, on an ongoing basis, Subcontractor's performance and accreditation. Subcontractor shall be subjected to formal review by Company. [State Contract §§ 4.3(C), 6.2(L)]

i. Any Subcontractor with NCQA/URAC or other national accreditation shall provide Company with a copy of its current certificate of accreditation, along with a copy of the survey report. [State Contract § 6.2(M)]

j. Subcontractor shall report suspected fraud and abuse to Company. [State Contract § 6.2(P)]

k. If Company delegates to Subcontractor any activities or obligations of Company under the State Contract, Company may revoke such delegation or impose other sanctions if the Subcontractor's performance is inadequate, all in accordance with the terms set forth in the Agreement. [State Contract § 4.3(A)]

l. If Company identifies deficiencies or areas for improvement in the Subcontractor's performance under the Agreement, Subcontractor shall cooperate with Company in taking all necessary corrective action. [State Contract §§ 4.3(D), 6.2(N)]

m. If Company delegates to Subcontractor the selection of Providers under the Agreement, Company shall retain the right to approve, suspend, or terminate any Provider selected by that Subcontractor. [State Contract § 4.3(E)]

n. Subcontractor shall at all times remain in compliance with the requirements of 42 C.F.R. § 438. [State Contract § 4.3(F)]

o. A Subcontractor that provides Covered Services shall inform Company if that Subcontractor itself engages a subcontractor in any transaction or series of transactions, in performance of any term of the State Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense. [State Contract § 6.3]

p. Subcontractor acknowledges that the State shall have the right to invoke against Subcontractor any remedy that is set forth in the State Contract, including the right to require the termination of any Subcontract, for each and every reason for which the State may invoke such a remedy against Company or for which the State may require the termination of the State Contract. [State Contract § 6.4]

q. If Company delegates to Subcontractor any utilization-management activities or obligations, Subcontractor shall ensure that all utilization-management programs, processes, and timeframes are in accordance with 42 C.F.R. §§ 431, 438, and 456, with the private-review agent requirements of Ky. Rev. Stat. Chapter 304.17A, and with the State Contract. Such Subcontractor shall adopt Interqual or Milliman for Medical Necessity, except in the event that Interqual or Milliman is not applicable to the specific service being provided, in which case Subcontractor may use other appropriate criteria so long as (1) that criteria or standard is a nationally recognized standard of which the State Department for Medicaid Services has received prior notice, and (2) Subcontractor has confirmed that Interqual or Milliman do not, in fact, contain standards applicable to the specific service being provided. With respect to behavioral-health Medical Necessity determinations, Subcontractor shall adopt the following standardized tools: for adults, Level of Care Utilization System (LOCUS); for children, Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths

Scale (CANS); for young children, Early Childhood Service Intensity Instrument (ECSII); and for substance use, American Society of Addiction Medicine (ASAM). [State Contract § 21.2]

r. If Company delegates to Subcontractor any credentialing or recredentialing activities/obligations, Subcontractor shall conduct all such activities/obligations in compliance with National Committee for Quality Assurance (NCQA) standards, with 907 KAR 1:672, with applicable federal law, and with the State Contract. [State Contract § 28.2]

s. Subcontractor acknowledges (1) that neither it nor its agents, officers, or employees shall be construed to be officers or employees of the State by virtue of the Agreement or the State Contract, and (2) that neither the Agreement nor the State Contract shall be construed as a partnership or joint venture between Subcontractor and the State. [State Contract § 41.7]

t. Subcontractor acknowledges that it is aware of the requirements and penalties outlined in KRS 45A.485, has properly disclosed all information required by this statute, and will continue to comply with such requirements for the duration of the State Contract. [KRS 45A.485]

u. Subcontractor acknowledges that it is aware of the requirements of Executive Order 2015-370 (Minimum Wage for State Employees and the Commonwealth's Service Providers) and that it will pay all workers working on or in connection with the State Contract a minimum of $10.10 per hour for all regular, hourly employees and a minimum of $4.90 per hour for all tipped employees for the duration of the State Contract. [Executive Order 2015-370]

13. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy-related Covered Services:

a. Provider/Subcontractor shall administer all pharmacy benefits in accordance with the provisions and requirements of Section 32.1 of the State Contract and in accordance with all applicable State and federal laws and regulations. [State Contract § 32.1]

b. If Company delegates to Provider/Subcontractor any pharmacy-related activities or obligations under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 32.0 of the State Contract. [State Contract §§ 32.0–32.11]

c. Provider/Subcontractor shall cooperate with Company with respect to Company's obligation to process, adjudicate, and pay pharmacy claims in accordance with Section 32.4 of the State Contract, and to submit National Drug Code (NDC) level information on drugs and diabetic supplies, including J-code conversions consistent with CMS requirements. [State Contract §§ 32.4, 32.5]

d. Provider/Subcontractor shall comply with the pharmacy prior-authorization provisions and requirements set forth in Section 32.6 of the State Contract. [State Contract § 32.6]

e. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract to (1) establish and maintain a generic-drug Maximum Allowance Cost (MAC) program, and (2) manage specialty pharmacy drugs. [State Contract §§ 32.7, 32.8]

14. Behavioral-Health Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to behavioral-health Covered Services:

a. Provider/Subcontractor shall administer all behavioral-health benefits in accordance with the provisions and requirements of Section 34.3 of the State Contract and in accordance with all applicable State and federal laws and regulations. [State Contract § 34.3]

b. If Company delegates to Provider/Subcontractor any behavioral-health-related activities or obligations under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 34.0 of the State Contract. [State Contract §§ 34.0–34.12]

c. Providers shall document DSM-V diagnosis and assessment/outcome information in the Member's medical record. [State Contract § 34.3]

d. If Provider is a PCP, Provider shall have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavior-health problems and disorders. PCPs may provide any clinically appropriate behavior-health services within the scope of their practice. [State Contract § 34.7]

e. Provider shall provide behavioral-health services (1) within twenty-four (24) hours of the referral if that service requires crisis stabilization, and (2) within forty-eight (48) hours of the referral if that service is for behavioral-health urgent care. A behavioral-health service appointment following a discharge from an acute psychiatric hospital shall occur within seven (7) days of discharge, and any behavioral-health service appointment not otherwise specified in this subparagraph shall occur within sixty (60) days of the referral. [907 KAR 17:015, § 2; State Contract § 34.8]

f. Provider that is providing behavioral-health services (1) shall refer a Member with known or suspected and untreated physical-health problems to the Member's PCP for examination and treatment with the consent of the Member or the Member's legal guardian; (2) may only provide physical-health services if it is licensed to do so; (3) shall send initial and quarterly (or more frequently if clinically indicated) summary reports of the Member's behavioral-health status to the PCP with the consent of the Member or the Member's legal guardian; and (4) shall ensure that all Members receiving inpatient behavioral-health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge, with Provider ensuring that such outpatient treatment occurs within seven (7) days from the date of discharge and with Provider contacting Members who have missed an appointment within twenty-four (24) hours to reschedule that appointment. [State Contract §§ 34.7, 34.8]

g. A Provider that is providing behavioral-health services: (1) shall ensure continuity of care for successful transition of Members back into community-based supports; (2) shall participate in quarterly continuity-of-care meetings hosted by State-operated or State-contracted psychiatric hospitals; (3) shall assign a case manager prior to or on the date of discharge and provide basic, targeted, or intensive case management services as Medically Necessary to Members with severe mental illness ("SMI") and co-occuring developmental disabilities who are discharged from a State-operated or State-contracted psychiatric facility for Members with SMI; (4) shall participate in discharge planning meetings to ensure compliance with federal *Olmstead* and other applicable laws, with discharge planning 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; (5) shall thereafter ensure the community supports are meeting the needs of the Member discharged from a State-operated or State-contracted psychiatric hospital; and (6) shall assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs. [State Contract § 34.10]

15. Access to Premises. Subcontractor shall allow duly authorized agents or representatives of the State or federal government or the independent external quality-review organization required by Section 1902(a)(30)(c) of the Social Security Act, 42 U.S.C. § 1396a(a)(30), access to Subcontractor's premises during normal business hours to inspect, audit, investigate, monitor, or otherwise evaluate Subcontractor's performance. If such access to Subcontractor is requested, Subcontractor shall provide and make staff available to assist in the audit or inspection effort, and shall provide adequate space on its premises to reasonably accommodate the State, federal, or external quality-review personnel conducting the audit, investigation, or inspection effort. In addition, Subcontractor shall produce all records, documents, or other data requested as part of such review, investigation, or audit. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Subcontractor's activities. [State Contract § 5.6]

16. Physician Incentive Plan Requirements. In the event compensation to Provider under the Agreement includes Physician Incentive Plans as defined by federal law, those Physician Incentive Plans shall comply with 42 C.F.R. §§ 417.479, 422.208, 422.210, and 438.6(h). Company shall make no specific payment directly or indirectly under a Physician Incentive Plan to Provider as an inducement to reduce or limit Medically Necessary Covered Services furnished to a Member. The Physician Incentive Plans shall not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. Company shall disclose to CMS information on Physician Incentive Plans in accordance with 42 C.F.R. §§ 417.479(h)(1) and 417.479(l) and at the times indicated in 42 C.F.R. § 417.479(d)–(g). Provider further acknowledges and agrees that in the event Provider is deemed to be at substantial financial risk under applicable Physician Incentive Plan regulations, Provider shall (i) cooperate and assist Company in conducting satisfaction surveys of Members using the Provider's services, and (ii) obtain, at Provider's sole expense, any additional stop loss insurance required pursuant to the Physician Incentive Plan regulations. In the event Provider must obtain stop loss insurance pursuant to the Physician Incentive Plan regulations, Provider shall obtain a stop loss policy with the following terms: (i) the policy is guaranteed renewable; (ii) termination of the policy shall not affect or reduce the policy insurer's obligation to cover, or responsibility for coverage of, the Provider's claims for Covered Services provided to Members during the term of such policy and which are covered under the applicable Plan; and (iii) the policy insurer will provide notice of termination or cancellation of the policy to Company. Bonus amounts paid pursuant to the Agreement, if any, shall not exceed 33% of the maximum payments possible to Provider for services that Provider furnishes directly to Members. [State Contract §§ 11.6, 11.7]

17. Stop-Loss Coverage. If Provider assumes substantial financial risk for contracted services, Provider shall maintain adequate stop-loss protection, sufficient proof of which, including the amount and type of stop-loss coverage maintained, shall be provided to Company by Provider upon request. [State Contract § 13.5]

18. Quality Assessment/Performance Improvement (QAPI) Program. Provider/Subcontractor shall participate in Company's Quality Assessment/Performance Improvement program activities (including but not limited to submission of complete encounter records), shall cooperate with Company with respect to Company's QAPI obligations under the State Contract, and shall cooperate with Company's Quality Improvement Committee. [907 KAR 17:025, § 6; State Contract §§ 19.1–19.4, 38.5]

19. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Provider/Subcontractor shall provide (and if Company delegates to Subcontractor the selection of Providers under the Agreement, Subcontractor shall ensure that its contracted Providers provide) EPSDT services to Members in compliance with the State Contract (and in particular Section 33.1 thereof), with 907 KAR 1:034, and with any policy statements issued by the State or CMS during the term thereof. Provider/Subcontractor shall also cooperate with Company with respect to Company's obligations under the State Contract to submit EPSDT reports to the State. [State Contract §§ 33.1, 38.9]

20. Third Party Liability. Provider/Subcontractor acknowledges and agrees that Medicaid payment, under the State Contract or otherwise, is secondary to other sources of payment for Covered Services provided to Members, and that Medicaid (and consequently Company, as a Medicaid MCO of the State) is the payer of last resort. Provider/Subcontractor furthermore acknowledges and agrees that when Company is aware of third-party sources of payment for Covered Services, Company is required by the State Contract to "cost avoid" (*i.e.*, deny) the associated claim and to redirect Provider/Subcontractor to bill that third-party source of payment as the primary payor. [State Contract § 14.2]

21. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to assist the State with its planning process for the State's CMS/CMMI State Innovative Model Design Award initiative, which involves the State partnering with health-system stakeholders to develop a State Healthcare Innovation Plan (SHIP). [State Contract § 5.7]

b. Company's obligation to notify the State of the existence and nature of any capitation agreement that Company has with Provider/Subcontractor pursuant to which Provider/Subcontractor

assumes risk, including without limitation information relating to how Provider/Subcontractor pays its downstream providers/subcontractors for providing Covered Services to Members. [State Contract § 6.5]

c. Company's obligation to cooperate with the State as part of any readiness review under the State Contract. [State Contract § 8.1]

d. Company's obligation to submit financial and expense-related reports/data to the State relating to the Risk Corridor Payment Adjustment and the Medical Loss Ratio Adjustment set forth in the State Contract. [State Contract §§ 11.4, 11.5]

e. Company's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [State Contract §§ 14.1, 14.2, 38.4]

f. Company's obligation to assist the State with verification that Providers are meeting the requirements of the Electronic Health Records Incentive Payment Program. [State Contract § 18.0]

g. Company's obligation to submit HEDIS reports/data to the State as set forth in the State Contract. [State Contract §§ 20.1–20.3]

h. Company's obligation to develop and implement Performance Improvement Projects as set forth in the State Contract. [State Contract § 20.5]

i. Company's obligation to provide orientation, education, and training for Providers as set forth in the State Contract. [State Contract § 28.5]

j. Company's obligation to reduce unnecessary emergency room visits so that the determination of non-emergent visits is reduced to no more than two (2%) percent in a rolling three (3) month period for that particular Medicaid region in the State. [State Contract § 29.7(J)]

k. Company's obligation to submit to the State claims-level cost data for payment-verification purposes relating to the State's supplemental payments, if any, under Section 30.11 of the State Contract. [State Contract § 30.11]

l. Company's obligation to conduct health risk assessments (HRAs) of Members as set forth in the State Contract. [State Contract § 35.1]

m. Company's obligation to perform care coordination and develop care plans for Members as set forth in the State Contract. [State Contract § 35.3]

n. Company's obligation to assist the State with its development of health homes for Company's medically complex Members. Once approved by CMS, Provider/Subcontractor shall comply with any health home program developed by the State. [State Contract § 35.4]

o. Company's obligation to coordinate with the Women, Infants and Children (WIC) program, including provision of medical information to the WIC program by Providers if requested by WIC agencies and if permitted by applicable law. [State Contract § 35.5]

p. Company's obligation to participate in transition planning and continued care coordination for Members with SMI who are transitioning from licensed personal-care homes, psychiatric hospitals, or other institutional settings to integrated, community-based housing, including the performance of a comprehensive physical and behavioral-health assessment designed to support the successful transition to community-based housing within fourteen (14) days of the transition. [State Contract § 36.6]

q. Company's obligation to respond to any letter of concern, written deficiency notice, or request for a corrective action plan that Company receives from the State relating to Subcontractor or the services that are within the scope of the Agreement. [State Contract § 40.4]

22. Hospitalists. Nothing in the Agreement shall require, or be construed to require, the mandatory use of a hospitalist (defined as a physician of record at a hospital for a patient of a participating physician and who may return the care of the patient to that physician at the end of the hospitalization). [KRS 304.17A-532]

23. Licensing/Certification. Provider/Subcontractor shall meet all appropriate licensing and contract requirements specified in applicable State and federal laws and regulations. This includes certification, where required, to provide those health care services in the State as set forth in the Agreement, including certification under CLIA, if applicable. Where applicable, Provider/Subcontractor shall have a valid Drug Enforcement Agency registration number and valid NPI and taxonomy. [State Contract § 3.5]

24. Notice of Legal Action. Subcontractor shall provide written notice to Company of any legal action or notice listed below, within ten (10) days following the date Subcontractor receives written notice of:

a. Any action, proposed action, lawsuit, or counterclaim filed against Subcontractor related in any way to the Agreement or the State Contract;

b. Any administrative or regulatory action, or proposed action, respecting the business or operations of Subcontractor related in any way to the Agreement or the State Contract;

c. Any notice received by Subcontractor from the Kentucky Department of Insurance or the Kentucky Cabinet for Health and Family Services;

d. Any claim made against Subcontractor by a Member having the potential to result in litigation related in any way to the Agreement or the State Contract;

e. The filing of a petition in bankruptcy by or against Subcontractor, or the insolvency of Subcontractor; and

f. The payment of a civil fine or conviction of any person who has an ownership or controlling interest in Subcontractor, or who is an agent or managing employee of Subcontractor, of a criminal offense related to that person's involvement in a program under Medicare, Medicaid, or Title XX of the Social Security Act, or of fraud, or unlawful manufacture, distribution, prescription, or dispensing of a controlled substance, as specified in 42 U.S.C. § 1320a-7.

[State Contract 41.4]

25. Termination of Agreement and Effect Thereof. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the Parties. Furthermore, in the event this Kentucky Medicaid Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or Product Participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties. In addition:

a. In the event of a breach of the Agreement by Company, the termination of the Agreement, or the insolvency of Company, Provider/Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Agreement for the remainder of any month for which the State has made payments to Company, and shall fulfill all of its obligations respecting the transfer of Members to other Providers/Subcontractors, including record maintenance, access, and reporting requirements, all such covenants, agreements, and obligations of which shall survive the termination of the State Contract and the Agreement. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527(1)(c); State Contract §§ 6.1, 40.8]

b. In the event of termination for any reason other than a quality of care issue or fraud, Company shall continue to reimburse Provider/Subcontractor in accordance with the Agreement until the Member is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater; and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement is terminated. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527(1)(b)-(c); State Contract § 40.8]

c. Company and/or Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall terminate from participation any Provider that (i) engaged in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked, or suspended; (iii) has medical staff privileges at any hospital terminated, revoked, or suspended; or (iv) engaged in behavior that is a danger to the health, safety, or welfare of Members. Company and such Subcontractor may also terminate the participation of any Provider that has materially breached the Agreement and has failed to timely and adequately cure such breach. [State Contract § 29.6]

26. Protected Health Information. Provider/Subcontractor shall abide by the same statutes and regulations regarding the confidentiality of protected health information that Company is itself subject to under the State Contract and state and federal law, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d) and 45 CFR Parts 160 and 164. Company shall conduct HIPAA privacy and security audits of Provider/Subcontractor as prescribed by the State. This confidentiality provision shall survive termination of the Agreement. [State Contract § 39.1, 39.2, 41.15]

27. Access to Records. Provider/Subcontractor shall make all of its books, documents, papers, records, medical records, data, surveys, computer databases, or other evidence (collectively, the "Records") available for examination, audit, and/or program review by the State, the Finance and Administration Cabinet, the Auditor of Public Accounts, the Legislative Research Commission, the Attorney General of the State, the Kentucky Department of Insurance, the U.S. Department of Health and Human Services, CMS, the Office of Inspector General Comptroller, authorized federal or State personnel, and the authorized representatives of the governments of the United States and the State including, without limitation, any employee, agent, or subcontractor of the State, CMS, or the State's fiscal agent, for a period of five (5) years after termination of the State Contract, except when an audit has been conducted or audit findings are unresolved. In such case, Records shall be kept for a period of five (5) years in accordance with 907 KAR 1:672, or as amended or until all audit issues are finally resolved, whichever is later. Access shall be at the discretion of the requesting authority and shall be either through onsite review of Records or by submission of Records to the office of the requesting authority. Any Records requested shall be produced immediately for onsite reviews or sent to the requesting authority by mail within fourteen (14) days following a request. All Records shall be provided at the sole cost and expense of Provider/Subcontractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping, and/or mailing of records. The State shall have unlimited rights to use, disclose, and duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by Provider/Subcontractor. [State Contract §§ 38.2, 39.1, 41.17, 41.21]

28. Medical Records. With respect to medical records:

a. In addition to the requirements set forth in the Agreement, Provider/Subcontractor shall maintain Member medical records on paper or in an electronic format. Provider/Subcontractor shall maintain Member medical records in a timely, legible, current, detailed, and organized manner 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 State Contract. Medical records shall be signed by the Provider/Subcontractor, as the case may be. [907 KAR 17:015, § 12; State Contract § 28.7]

b. Although the medical records are the property of the Provider/Subcontractor that generates the record, each Member or the Member's representative is entitled to one (1) free copy of his/her medical record. Additional copies shall be made available at cost. Provider/Subcontractor shall preserve and maintain Member medical records for no less than five (5) years unless federal requirements mandate a longer retention period (*i.e.,* immunization and tuberculosis records shall be maintained for a Member's lifetime). [907 KAR 17:015, § 12; State Contract § 28.7]

c. Provider/Subcontractor's medical records shall meet the medical record standards that Company and the State Contract require for medical-chart organization and documentation, for the contents of the medical record, and for individual clinical-encounter documentation. Medical records will reflect all aspects of patient care, including ancillary services. Additionally, a PCP's primary medical record for each Member must contain sufficient medical information from all providers involved in that Member's care to ensure continuity of care. [State Contract § 28.7]

d. If any Covered Service provided by Provider/Subcontractor requires 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). Provider/Subcontractor shall retain that form in the event of an audit and a copy shall be submitted to the State upon request. [State Contract § 31.1]

e. If a Member changes PCPs, Provider/Subcontractor shall forward the medical records or copies thereof to the new PCP or provider within ten (10) days of the request. The PCP shall have the Member sign a release of medical records before a medical record transfer occurs. [State Contract § 39.1]

29. Licensing Requirements; Malpractice Insurance.

a. Provider/Subcontractor shall be properly licensed in accordance with all applicable State laws and regulations and shall have in effect a current policy of malpractice insurance as Company may require. [State Contract, Appendix J]

b. Provider/Subcontractor shall comply with Company's verification of Provider/Subcontractor's credentials and insurance coverage, including without limitation completing a credentialing application in accordance with the State's policies and procedures. [907 KAR 17:015, § 4; State Contract, Appendix J]

c. Provider cannot enroll or continue participation in Company's network if Provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if the Provider's required licenses and certifications are not current, if the Provider owes money to the Medicaid Program, if the office of the Attorney General has an active fraud investigation involving the Provider, or if the Provider otherwise fails to satisfactorily complete the credentialing process. [State Contract § 29.3]

30. Disclosure of Ownership and Control.

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in federal health care programs, or is 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, Provider/Subcontractor shall disclose to Company: any required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest information; and information on any criminal convictions regarding Provider/Subcontractor and any owner(s) and managing employee(s) at the time this Agreement is executed and annually thereafter, and any time there are changes to such information. [State Contract § 38.15]

b. No Provider, no individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider, and no officer, director, agent, or managing employee (*i.e.*, general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over that Provider or who directly or indirectly conducts the day-to-day operation of that Provider) shall be an entity or individual: (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)–(3) of the Social Security Act (42 U.S.C. § 1320a-7(b)(1)–(3)); (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a State health care program. [State Contract § 3.6]

31. Orientation and Training. Provider shall require its officers and medical staff to attend initial orientation conducted by Company within thirty (30) days after Provider is placed on active status, and shall require same to attend any ongoing orientation and education required by Company as necessary to ensure full compliance with the State Contract and all applicable federal and State requirements. [907 KAR 17:015, § 7; State Contract § 28.5]

32. Advances and Loans. Company shall not, without thirty (30) days' prior written notice to and approval of State, make any advances to Subcontractor (not including capitation payments or payments made by Company to Company's network for the provision of Covered Services). [State Contract § 13.4]

33. Marketing Activities. Provider/Subcontractor shall comply with all allowable and unallowable marketing activities and practices pursuant to 42 C.F.R. § 438.104, and shall submit to Company for its review any marketing or information materials of Provider/Subcontractor that relate to the State Contract, prior to disseminating same. The State shall have the same approval authority for Subcontractor marketing materials as over Company's materials. [State Contract §§ 26.1, 26.2]

34. Advance Medical Directives. If Provider is a PCP, Provider shall have the responsibility to discuss advance medical directives with all adult Members at the first medical appointment of a Member and chart that discussion in the medical record of such Member. [State Contract §§ 28.3 & 28.8]

35. Accounting System. Provider/Subcontractor shall maintain its accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted systems of accounting. The accounting system shall clearly document all financial transactions between Company and Provider/Subcontractor. These transactions shall include, but not be limited to, claims payment, refunds, and adjustment of payments. [State Contract § 38.14]

36. Compliance with Laws. Provider/Subcontractor shall adhere to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; the Americans with Disabilities Act of 1990, as amended; the Rehabilitation Act of 1973, as amended; Sec. 202 of Executive Order 11246, as amended; and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. Provider/Subcontractor shall not discriminate in the rendering of services to and/or employment of individuals because of race, gender, color, religion, sex, age, national origin, sexual orientation, gender identity, handicap, political beliefs, disabled veteran status, veteran status, or any other non-merit factor. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor, through quality-assurance audits and otherwise, Subcontractor's compliance with the nondiscrimination provisions set forth in this Kentucky Medicaid Addendum. Subcontractor must also comply with the rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741, and regulations of the United States Department of Labor recited in 20 C.F.R. Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*) and its implementing regulation at 45 C.F.R. Part 80, Provider/Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement.

Provider/Subcontractor's locations shall meet all requirements of the Americans with Disabilities Act and all State and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures that are applicable to health care facilities. [State Contract §§ 5.3, 5.4]

37. State Hold Harmless. Provider/Subcontractor shall indemnify, defend, save, and hold harmless the State and its officers, agents, and employees (collectively, the "State Indemnified Parties") from all claims, demands, liabilities, suits, judgments, or damages, including court costs and attorney fees made or asserted against or assessed to the State Indemnified Parties, arising out of or connected in any way with the State Contract or the performance or nonperformance by Company, by Provider/Subcontractor, or by any officers, agents, employees, suppliers, subcontractors, or providers of any of the foregoing, including without limitation any claim attributable to:

a. The improper performance of any service, or improper provision of any materials or supplies, irrespective of whether the State knew or should have known such service, supplies, or materials were improper or defective;

b. The erroneous or negligent acts or omissions, including without limitation the disregard of federal or State law or regulations, irrespective of whether the State knew or should have known of such erroneous or negligent acts;

c. The publication, translation, reproduction, delivery, collection, data processing, use, or disposition of any information to which access is obtained pursuant to the State Contract in a manner not authorized by the State Contract or by federal or State law or regulations, irrespective of whether the State knew or should have known of such publication, translation, reproduction, delivery, collection, data processing, use, or disposition; or

d. Any failure to observe federal or State law or regulations, including but not limited to insurance and labor laws, irrespective of whether the State knew or should have known of such failure.

[State Contract § 13.2]

Exhibit A.6

Individual Sites Regulatory Compliance Addendum (Louisiana)

PROGRAM PARTICIPATION SCHEDULE

Delegated Entity agrees to participate in the Plans and other health benefit programs listed herein:

- Those Louisiana Medicaid and CHIP Plans and programs offered by Company within the State of Louisiana. Includes Bayou Health, Managed Long Term Services and Supports, Behavioral Health, Basic Health Plans, Bridge Plans or other health plans offered to Medicaid-eligible enrollees.
- Those Medicare plans for Medicaid enrollees offered by Company within the State of Louisiana. Includes Medicare D-SNP and integrated Medicare-Medicaid Plans.
- Those Qualified Health Plans, whether purchased on the exchange or in the private market, offered by Company within the State of Louisiana.

Individual Sites Regulatory Compliance Addendum – Exhibit A.7

Louisiana Medicaid/CHIP Compliance Addendum

This Compliance Addendum ("Addendum") is incorporated by reference into the Agreement. This Addendum applies to Medicaid and CHIP products, including the Bayou Health Program and the eligible populations covered by the State Contract. The provisions in this Addendum are required by the Bayou Health Program of all health care providers, downstream services providers, and subcontractors, including but not limited to suppliers and/or vendors, of Aetna Better Health, Inc. d/b/a Aetna Better Health of Louisiana.

For purposes of this Addendum, the term "Supplier" shall mean the individual or entity executing the Agreement, which may be a health care physician, provider, group, facility, hospital or an individual or entity.
The Bayou Health RFP can be found at:
http://dhh.louisiana.gov/assets/docs/contracts/BayouHealthPrepaidFINAL72814.pdf

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, as and if amended, then the terms of the State Contract will govern and control. If any requirement in the Agreement or this Addendum is determined by DHH to conflict with the contract between DHH and Company, such requirement shall be null and void and all other provisions shall remain in full force and effect.

To the extent applicable to services provided by Supplier pursuant to the Agreement, the following provisions apply.

I. DEFINITIONS

Bayou Health (or Bayou Health Program). The full risk-bearing MCO health care delivery system, authorized by La. R.S. 36:254 and operated by DHH under the authority of the State Plan Amendment, responsible for providing specified Medicaid core benefits and services included in the Louisiana Medicaid State Plan to Medicaid recipients.

Behavioral Health Services ("BHS"). Mental health and substance abuse services, which are provided to Enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. BHS may be basic or specialized. Basic BHS are provided in the Enrollee's PCP office by the Enrollee's PCP as part of primary care service activities, as well as those services provided in an FQHC ("Federally Qualified Health Center"). Specialized mental health services shall include, but not be limited to, services specifically defined in the Medicaid State Plan (or as otherwise authorized by the Bayou Health program) and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider to those Enrollees with a primary diagnosis of a behavioral disorder.

Children's Health Insurance Program ("CHIP"). The program created in 1997 by Title XXI of the Social Security Act and known in Louisiana as CHIP.

Claim. In addition to the provisions of this Agreement, Claim means (1) a bill or services, (2) a line item of service or (3) all services for one recipient within a bill.

Clean Claim. A Clean Claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a Claim with errors originating in a State's Claims system. It does not include a Claim from a provider who is under investigation for fraud or abuse, or a Claim under review for medical necessity.

Covered Services. Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Louisiana Medicaid State Plan.

Emergency Services. Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. § 438.114(a) and Section 1932(b)(2) of the Social Security Act and that are needed to screen, evaluate and stabilize an emergency medical condition. Services defined as such under Section

1867(e) of the Social Security Act ("anti-dumping provisions"). If an emergency medical condition exists, the MCO is obligated to pay for the Emergency Service. Coverage of Emergency Services must not include any prior authorization requirements, and the "prudent layperson" standard shall apply to both in-plan and out-of-plan coverage.

Enrollee. A Louisiana Medicaid or CHIP recipient who is currently enrolled in an MCO or other Medicaid managed care program.

Louisiana Department of Health and Hospitals ("DHH"). 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 Louisiana.

Louisiana Medicaid State Plan. The binding written agreement between DHH and CMS, which describes how the Medicaid program is administered and determines the services for which DHH will receive federal financial participation.

Managed Care Organization ("MCO"). A private entity that contracts with DHH to provide core benefits and services to Enrollees in exchange for a monthly prepaid capitated amount per Member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to La. R.S. 22:1016, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid program be regulated by DHH.

Managed Care Program. The Louisiana Medicaid program providing statewide leadership to most effectively utilize resources to promote the health and well-being of Enrollees in the Bayou Health Program.

Material Changes. Material Changes are changes affecting the delivery of care or services provided under the State Contract. Material Changes include, but are not limited to, changes in composition of the provider network, subcontractor network, the MCO's complaint and grievance procedures; health care delivery systems, services, changes to expanded services; benefits; enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that require DHH approval prior to implementation; and the MCO's capacity to meet minimum enrollment levels. DHH shall make the final determination as to whether a change is material.

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 Record. A single complete record kept at the site of the Member's treatment(s), which documents medical or allied goods and services, including, but not limited to, outpatient and emergency medical health care services whether provided by the MCO, its subcontractor or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211.

Medically Necessary or Medical Necessity. Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) 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. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid

coverage and will be deemed "not medically necessary." Additionally, the Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by-case basis.

Member. As it relates to the Louisiana Medicaid/CHIP programs, the State Contract and this Agreement, Member refers to a Medicaid/CHIP eligible who enrolls in an MCO under the provisions of the State Contract and also refers to an "Enrollee" as defined in 42 C.F.R. § 438.10(a).

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 this Agreement, Policies include the general principles by which DHH is guided in its management of the Title XIX program, as further set forth and defined by DHH promulgations and by state and federal rules and regulations.

Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain, improve or resolve the Member's condition, pursuant to 42 C.F.R. § 422.113(c)(1) and § 438.114.

Primary Care Provider ("PCP"). An individual physician, nurse practitioner or physician assistant who accepts responsibility for the management of a Member's health care. The Primary Care Provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care) or admit the patient to a hospital.

State Contract. The written agreement between Company and DHH, the Government Sponsor, a copy of which shall be furnished to Supplier upon request. 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. [RFP §2.3.2]

2. SUPPLIER SERVICES AND OBLIGATIONS

2.1 Licensing Requirements. Supplier must be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain, throughout the term of this Agreement, all necessary licenses, certifications, registrations and permits as are required to provide Covered Services or perform other activities delegated by Company. If DHH or Company discovers that Supplier is not properly licensed by the appropriate authority, Supplier shall immediately discontinue providing services to Members. Upon proper licensing by the appropriate authority and approval by DHH, Company may reinstate Supplier to provide services to Members. [RFP §14.5.1 & Appendix O, #14]

2.2 Suspension or Debarment. Supplier acknowledges and understands that Company shall not execute contracts with any provider who has been excluded from participation in the Medicare and/or Medicaid programs pursuant to § 1128 (42 U.S.C. § 1320a-7) or § 1156 (42 U.S.C. § 1320 c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare programs. Supplier further acknowledges that Company is prohibited from entering into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders or state adverse actions. [RFP § 4.1.2, 7.13.6, 15.1.11 & 25.13.1]

2.3 Supplier Services Requirements. Supplier must provide, or arrange for the provision of, Covered Services or coverage of core benefits and services in the amount, duration and scope of core benefits and services specified in the Louisiana Medicaid State Plan, as well as all specific requirements of the State Contract, services under this Agreement to Members through the last day that this Agreement is in effect. Supplier acknowledges that all final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee. In the event that Supplier is unable or unwilling to provide services to Members, Supplier shall notify Company within one (1) business day. [RFP §7.11.6 & Appendix O, #12 & 15]

2.4 Fraud and Abuse Policies. To the extent applicable, Supplier, on behalf of itself and any subcontractors, agrees to comply with applicable provisions of the State Contract and Company's Fraud and Abuse Compliance Plan or other compliance program developed by Company to prevent, reduce, detect, correct and report known or

suspected fraud, waste and abuse in the administration and delivery of health care services. Supplier shall abide by all requirements of the State Contract regarding right of review and recovery by Company and DHH for possible acts of fraud, waste and abuse for services under this Agreement, including those rules governing complex reviews and potential overpayments and/or underpayments. As a condition of receiving any amount of payment, Supplier shall comply with Section 15 of the RFP. [§15.1.1, 15.1.19, 15.1.22 & 25.20]

2.5 Byrd Anti-Lobbying Amendment. Supplier further agrees to comply with the Byrd Anti-Lobbying Amendment, which provides that contractors who apply or submit bids shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. § 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier, up to the recipient (45 C.F.R. § 3). [RFP §25.2.1.13]

2.6 Referrals. As applicable to services provided under the Agreement, Supplier shall adhere to Company's referral system and guidelines to ensure that services are furnished to Enrollees promptly and without compromise to care. Supplier agrees to cooperate with Company with requested reporting and monitoring activities regarding referrals and ensure that documentation of specialty health care and out-of-network referrals, services and follow-up activities are included in the Medical Record maintained by the Member's PCP. Supplier also agrees to adhere to Company's procedures and criteria for making referrals and coordinating care with behavioral health providers and agencies that will promote continuity, as well as, cost-effective care. [RFP §§6.28 & 6.34.7]

2.7 Responsibilities of Primary Care Providers. If Supplier is a PCP, the PCP shall serve as the member's initial and most important point of interaction. The PCP shall also be responsible for the following: [RFP §7.8.2]

(a) Managing and coordinating the medical and health care needs of members to assure that all Medically Necessary services are made available in a timely manner;

(b) Referring patients to subspecialist and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;

(c) Communicating with all other levels of medical care to coordinate and follow-up the care of individual patients;

(d) Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid fee-for-service ("FFS");

(e) Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care;

(f) Development of a plan of care to address risks and medical needs and other responsibilities regarding care management as set forth in Company Policies and the State Contract;

(g) Ensuring that in the process of coordinating care, each Enrollee's privacy is protected consistent with the confidentiality requirements of state law and those set forth in 45 C.F.R. Parts 160 and 164, which set forth the requirements regarding the privacy of individually identifiable health information;

(h) Providing after-hours availability to patients who need medical advice. At a minimum, PCP offices must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within thirty (30) minutes of the call;

(i) Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital; and

(j) Provide basic BHS and refer Members to the appropriate health care specialist as deemed necessary for specialized BHS.

2.8 Medically Necessary/Preventive Services. Supplier may not refuse to provide medically necessary or covered preventive services to Members covered under this Agreement or the State Contract for non-medical reasons (except those services allowable under federal law for religious or moral objections). However, Supplier is not required to accept or continue treatment of a patient with whom Supplier feels he/she cannot establish and/or maintain a professional relationship. [RFP Appendix O, #13 & 18]

2.9 Emergency Services. Supplier shall render Emergency Services without the requirement of prior authorization of any kind. Supplier agrees to cooperate with Company's obligations to monitor utilization of Emergency Services and correct inappropriate emergency department utilization. [RFP §6.8.1.1 & Appendix O, #16]

2.10 Laboratory Services. If Supplier performs laboratory services, Supplier must meet all applicable federal and state law requirements, including the provisions of 42 CFR § 493.1 and § 493.3. [Appendix O, #17]

2.11 Behavioral Health Services. DHH and Company support the integration of physical services and BHS through screening and strengthening prevention/early intervention at the primary care level of care. As applicable, Supplier shall utilize behavioral health screening tools and protocols consistent with industry standards. PCP and Company shall collaborate with behavioral health specialists, including but not limited to, psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, mental health rehabilitation service providers (public or private) and other specialty behavioral health providers, to ensure the provision of services to Members as specified in the Medicaid State Plan. In addition, Supplier is not permitted to encourage or suggest, in any way, that Members be placed in state custody to receive medical or specialized BHS covered by DHH. [RFP §§6.4.6, 6.4.8 & Appendix O, #19]

2.12 Transportation Services. If applicable, for medically necessary non-emergent transportation requested by a Member or someone on behalf of a Member, the transportation contractor or Supplier shall schedule the transportation so that the Member arrives on time but no sooner than one (1) hour before an appointment; nor have to wait more than one (1) hour after the conclusion of the appointment or treatment for transportation home; nor be picked up prior to the completion of treatment. [RFP §7.8.9.2]

2.13 Telehealth/Telemedicine. With respect to the practice of telehealth and telemedicine, including the provision of goods and services related to the provision of telehealth and telemedicine services, Supplier agrees to comply with all applicable state laws and rules, including any rules and guidance issued by the Louisiana State Board of Medical Examiners ("LSBME"), DHH or other state agency. [La. R.S. 37:1262 *et seq.* & 40:1300.401 *et seq.*]

2.14 Treatment Decisions. As applicable to services provided under the Agreement, Supplier shall be familiar with the package of benefits offered by DHH set forth in the State Contract and DHH's requirement that providers make treatment decisions based upon individual medical needs. Supplier must comply with DHH's requirements governing Member rights and responsibilities as set forth in State Contract, Company Policies and applicable state and federal law. [RFP §12.16.15.1]

2.15 Appointment System. As applicable to services provided under the Agreement, Supplier shall abide by the appointment availability access standards for core benefits and/or expanded services to ensure that Members' needs are sufficiently met. Supplier shall ensure that appointments are on a timely basis, as follows: [RFP §7.1.3]

(a) Routine, non-urgent or preventive care visits scheduled within six (6) weeks;
(b) Urgent care visits within twenty-four (24) hours. Supplier must provide or make arrangements, as directed by Company or through other arrangements, for a patient to obtain urgent care twenty-four (24) hours per day, seven (7) days per week;
(c) Emergent or emergency visits immediately upon presentation at a service delivery site. Emergency Services must be available at all times;
(d) Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;
(e) In office waiting times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time in the waiting room and examining room. If Supplier is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment;
(f) Maternity Care:

(i) Initial appointment for prenatal visits for newly enrolled pregnant women, who must be treated without unreasonable delay, shall meet the following timetables from the postmark date the MCO mails the member's welcome packet:
  (1) In the first trimester within fourteen (14) days;
  (2) In the second trimester within seven (7) days;
  (3) In the third trimester within three (3) day;

(ii) High risk pregnancies within three (3) days of identification of high risk by Company or maternity care provider, or immediately if an emergency exists;

(g) Specialty care consultation within one (1) month of referral or as clinically indicated;

(h) Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated;

(i) Follow-up to emergency department visits in accordance with emergency department attending provider discharge instructions;

(j) Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures; and

(k) Direct contact with a qualified clinical staff person must be available through a toll-free number at all times.

2.16 Insurance. Supplier shall secure and maintain throughout the term of this Agreement, all necessary insurance of the same nature, as applicable to the services hereunder, and in the same amount as required of Company under the State Contract, including but not limited to, liability, workers' compensation and malpractice insurance or other coverage as is necessary to adequately protect Members and Company under this Agreement. Supplier shall furnish Company with written verification of the existence of such coverage at all times during this Agreement. Supplier shall not commence performance under this Agreement until all insurance requirements have been obtained and a copy provided to and approved by Company. Supplier shall not cancel permit to expire, or change any policy without providing thirty (30) days' advance notice to Company and DHH and receive Company and DHH's consent in writing. Supplier's policies shall so reflect this requirement. Payment of any deductible shall be the sole responsibility of Supplier. [RFP §2.5 & Appendix O, #38]

2.17 No Interference by Company. Subject to the limitations set forth in 42 C.F.R. § 438.102(a)(2), Company agrees that it shall not prohibit or otherwise restrict Supplier, acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, regardless of whether benefits for such care or treatment are provided under the State Contract, for the following: [RFP §7.14.1.6 & Appendix O, #51]

(a) The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the Enrollee needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; and

(d) The Enrollee'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.

2.18 Required Disclosures. Supplier shall comply with the disclosure provisions of 42 C.F.R. § 455, Subpart B and disclose all required information regarding significant business transactions, ownership and control information to Company, as well as otherwise required by applicable law. Supplier shall complete the Louisiana form, which can be found at: [RFP §§2.3.1 & 15.1.10 & Appendix O, #24]
http://new.dhh.louisiana.gov/assets/docs/BayouHealth/RFP2014/Appendices/AppendixVV_MCO_AnnualDisclosures.pdf

2.19 Training. Supplier shall participate in training sessions provided by Company to ensure that Supplier, and any subcontractors, adhere to Company policies and procedures and Medicaid regulations to fulfill their requirements, including all restrictions and limitations on marketing guidelines. [RFP §§12.1-12.10]

2.20 Covered Population. Supplier shall provide services to the enrollment populations identified in and in accordance with the State Contract, as amended from time to time. [RFP Appendix O, #11]

2.21 Offshoring. Supplier shall perform all services under this subcontract entirely within the boundaries of the United States. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. [RFP §25.26]

2.22 Compliance with State Contract. Supplier shall adhere to all requirements set forth for MCO subcontractors in the contract between DHH and the Company, including the department issued guides. Company will furnish these documents to the Supplier upon request. [RFP §2.3.2 & Appendix O, #2]

2.23 Audit. If Supplier is performing a key internal control, Supplier shall submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by DHH, the subcontractor must provide a quality control plan, such as third party Quality Assurance ("QA"), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits. [RFP §§17.11.2.5, 21.9 & 25.47]

2.24 Background Checks. Supplier shall comply with DHH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of DHH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request, provide Company or DHH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of the Agreement. [RFP §4.1.4]

2.25 Coordination with Other Service Providers. As applicable to the services provided under the Agreement, Supplier is encouraged to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee). [RFP §§7.12 & 25.10]

3. CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Compensation. Supplier shall promptly submit accurate information needed to make payment under the terms of the Agreement, identifying the name and address of the official payee to whom payment shall be made and the method and amount of compensation. Supplier shall make full disclosure of the method and amount of compensation or other consideration received from Company. In accordance with 42 C.F.R. § 438.210(e), Supplier is not compensated to provide incentives for Company to deny, limit, or discontinue medically necessary services to any Member. In the event DHH deducts or withholds payments due Company as a result of assessments made due to Supplier's performance or nonperformance, Company shall withhold the same amount from any monies owed to Supplier. Supplier shall be liable for any loss of federal financial participation suffered by DHH due to Supplier's failure to perform the services as required under the Agreement. [RFP §§25.3, 25.32 & Appendix O, #1, 31-33, 47]

3.2 Payment of Claims. Company agrees to pay 90% of all Clean Claims submitted by Supplier within fifteen (15) business days of the date of receipt and 99% of all Clean Claims submitted by Supplier within thirty (30) business days of the date of receipt. The date of receipt is the date that Company receives the Claim, as indicated by the date stamp on the Claim. The date of payment is the date of the check or other form of payment. Company and Supplier may, by mutual agreement, establish an alternative payment schedule herein. Supplier must submit all Claims for Covered Services for payment no later than one hundred and eighty (180) days from the date of service. [RFP §§17.2.1-17.2.4 & Appendix O, #34-35]

3.3 Capitation Arrangement Payments. With respect to payments made through a capitation arrangement, Supplier shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of FFS Claims. If Supplier becomes aware for any reason that he or she is not entitled to a PMPM payment for a particular Member (i.e., patient dies), Supplier shall immediately notify both Company and DHH by certified mail, return receipt requested. Supplier acknowledges and understands that such capitation arrangements may be subject to adjustment. [RFP §§17.8.3 & 17.8.9]

3.4 Timely Reimbursement. In the event that DHH deems Company unable to timely process and reimburse Claims, and requires Company to submit Claims for reimbursement to an alternate Claims processor, if applicable, to ensure timely reimbursement, Supplier agrees to accept reimbursement at no more than the Company's contracted reimbursement rate or DHH's established FFS rate.

3.5 In-Network Reimbursement. Unless mutually agreed upon by the Parties, Suppliers who are in-network providers shall not be reimbursed by Company for defined core benefits and services at less than the Medicaid FFS rate in effect on the date of service or its equivalent (such as a DRG case rate). [RFP §9.1 & Appendix O, #1]

3.6 Member Billing. Supplier shall accept payment for Covered Services made by Company under the terms of this Agreement as payment-in-full and shall not solicit or accept any surety or guarantee of payment from DHH or any Member, which shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally responsible person of the Member being served. In accordance with federal law and regulations, Supplier shall not bill Members any amount greater than would be owed if Company provided the services directly. To the extent cost sharing is required of a Member, Supplier shall not deny services because of the individual's inability to pay. Members shall not be held liable for the costs of any and all services not covered by Company or in cases where Supplier failed to obtain required authorization. [RFP §§5.13.1, 25.25 & Appendix O, #36]

3.7 FQHC/RHC ("Rural Health Center") Reimbursement. Company shall reimburse a contracted FQHC/RHC at an amount equal to the Prospective Payment System ("PPS") rate in effect on the date of service of each encounter. As applicable, Supplier agrees and understands that Company shall not enter into alternative reimbursement arrangements with FQHCs or RHCs. [RFP §9.2 & Appendix O, #50]

3.8 Compensation for UM Activities. In accordance with federal law and regulations, any compensation to Company, entities or individuals that conduct utilization management activities is not structured so as to provide incentives for the entity, individual or Company to deny, limit or discontinue medically necessary services to any Member. [RFP Appendix O, #47 & 57]

3.9 Encounter Errors. If Supplier discovers an error or a conflict with a previously adjudicated encounter claim, Company shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent Company from meeting this time frame a specified date shall be approved by DHH. [RFP §17.8.18]

3.10 Incentive Plans. Any and all incentive plans shall comply with 42 C.F.R. § 438.6(h). [RFP §25.39.1]

4. COMPLIANCE WITH POLICIES

4.1 Compliance with Applicable Law. Supplier agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines, including Constitutional provisions regarding due process and equal protection, applicable to the provision of services under the Bayou Health Program [*See* RFP §25.2.1 for a list & Appendix O, #39]

4.2 Reporting Communicable Diseases. Supplier shall comply with the La. Admin. Code; Sanitary Code, Title 51, Part II, Chapter 1 and La. R.S. 40:4 *et seq.* if Supplier is required to report all cases of communicable diseases such as tuberculosis, sexually transmitted diseases and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome infection to the state public health agency within twenty-four (24) hours of notification from the date of service.

4.3 QAPI and UM Programs. To the extent applicable to Supplier, Supplier shall adhere to the Quality Assessment and Performance Improvement Program ("QAPI") and Utilization Management ("UM") requirements specified by DHH and Company, including those set forth in the State Contract. Such requirements shall be incorporated into this Agreement. [RFP §14.5.3 & Appendix O, #45]

4.4 Grievance System. Company will provide Supplier with information regarding Company's grievance system that complies with state and federal laws, including 42 C.F.R. § 438, Subpart F. Supplier agrees to adhere to

the requirements of Company's grievance and appeals procedures. Supplier shall comply with Company's Policies for grievance and appeal procedures as well as facilitate Member grievance and appeals and assist Members as required. No punitive action will be taken against any provider who files on behalf of a Member. [RFP §13.0]

4.5 Record Keeping System. Supplier shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly accepted information elements for Covered Services rendered to Members under the terms of this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed). Company, Members and their representatives shall be given access to and can request copies of Members' Medical Records to the extent and in the manner provided by La. R.S. 40:1299.96 and 45 C.F.R. § 164.524 and as subject to reasonable charges. [RFP §§ 15.1.3, 25.45 & Appendix O, #20]

4.6 Maintenance of Medical Records. Supplier shall maintain a unified Medical Record for each Member following Company's documentation guidelines regarding medical records, and the medical record documentation guidelines set forth in the State Contract. [RFP §15.6 & Appendix O, #20-21]

4.7 Record Retention Policy. All records originated or prepared in connection with Supplier's performance of its obligations under this Agreement, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by Supplier in accordance with the terms and conditions of the State Contract and this Agreement. Supplier agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under this Agreement, and as further required by DHH, for a period of six (6) years after the last payment was made for services provided to a Member and retained further if the records are under review, audit, or related to any matter in litigation until the review, audit, or litigation is complete. If any litigation, claim or other actions involving the records have been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the six (6) year period, whichever is later. If Supplier stores records on microfilm or microfiche, Supplier shall produce, at its expense, legible hard copy records upon the request of state or federal authorities, within twenty one (21) calendar days of the request. [RFP §25.43 & Appendix O, #22, 54 & 55]

4.8 Medicaid Records Retention. Except for Medical Records pertaining to once-in-a-lifetime events, Supplier shall retain any and all Member records (financial, medical, etc.) for a period of six (6) years after the last payment was made for Covered Services provided to a Member (or any greater period of time required by applicable federal and state law) or longer if the records are under review, audit, or related to any matter in litigation until the review, audit or litigation is complete. This requirement pertains to the retention of records for Medicaid purposes only. Other state or federal laws may require longer retention periods. Per La. R.S. 40:1299.96, providers must retain their records for at least six (6) years. These minimum record keeping periods run from the last date of treatment. After these minimum record-keeping periods, destruction of records is permitted. Supplier shall ensure that any and all Member records are made available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of DHH or its authorized representative. [La. R.S. 40:1299.96; RFP §15.6 & Appendix O, #22]

4.9 Access to Information and Records. Supplier acknowledges and understands that state authorities, such as DHH, the State Auditor's Office and the Louisiana Attorney General's Office, shall have the right to evaluate, through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract and this Agreement, including documents related to the quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Claims submitted to Company. Such evaluation, when performed, shall be performed with the cooperation of Supplier. Upon request, Supplier shall assist in such review. Supplier shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The Company shall provide originals and/or copies (at no

charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested. [RFP §15.1.3, 15.1.4 & Appendix O, # 23 & 25]

4.10 Program Procedures. Supplier agrees to participate and cooperate in any internal and external quality assessment review, utilization management and grievance procedures established by Company, DHH and/or its designee, whether announced or unannounced. Supplier further agrees to comply with all limitations on Supplier marketing and any corrective action plan initiated by Company and/or required by DHH. Supplier shall monitor and report the quality of services provided under this Agreement and, if necessary, initiate a plan of correction to improve the quality of care in accordance with that level of care which is recognized as acceptable professional practice in Supplier's community and/or the standards established by Company, DHH and/or its designee. [RFP Appendix O, #25-27]

4.11 Reports to Company. Supplier shall provide and cooperate with Company to provide all reports and clinical information required for reporting purposes, including but not limited to, HEDIS, AHRQ, EPSDT, etc. [RFP §18.0 & Appendix O, #29]

4.12 Member Information. Supplier shall safeguard Member information in accordance with applicable state and federal laws and regulations and the policies and safeguards established by Company. [RFP §25.48 & Appendix O, #30]

4.13 Notice of Legal or Administrative Actions. Supplier shall provide Company with immediate notification in writing by certified mail of any litigation, investigation, administrative legal action, complaint, claim or transaction that may reasonably be considered to have a material impact on Supplier's ability to provide services under this Agreement. Supplier shall also provide prompt notice of any claim made against Supplier by a third party, including a Member, that may result in litigation related in any way to Company's State Contract with DHH. [RFP Appendix O, #46]

4.14 Reporting of Births. To the extent applicable and if Supplier is a hospital, Supplier must report the births of newborns within twenty-four (24) hours of birth for enrolled Members using DHH's web-based Facility Notification System. If Supplier is a hospital, Supplier shall accurately register all births through the Louisiana Electronic Event System ("LEERS") administered by DHH/Vital Records Registry. [RFP §11.10.4.2 & Appendix O, #49 & 58]

4.15 Records Upon Termination. Company and Supplier recognize and agree that in the event of termination of the State Contract between Company and DHH, Supplier shall immediately make available to Company or its designated representative and to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to Company's and Supplier's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to DHH. [RFP Appendix O, #8 &42]

4.16 Failure to Comply with Contractual or Credentialing Requirements. In the event Supplier fails to comply with specific contractual and/or credentialing requirements as set forth in this Agreement or Company Policies, Supplier may be subject to monetary penalties, sanctions or reductions in payment, which shall include, but may not be limited to Supplier's failure or refusal to respond to Company's request for information, the request to provide medical records, credentialing information, etc. Penalties shall be imposed at the Company's discretion or by a directive of DHH that Company impose, at a minimum, financial consequences against Supplier as appropriate. [Appendix O, #28]

4.17 Assistance to Members. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d, *et seq.*) and 45 C.F.R. Part 80, Supplier must take adequate steps, including coordination with Company, to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement. [RFP §25.2.1.3 & Appendix O, #52]

4.18 PCP Linkages. If Supplier is a PCP, the maximum number of linkages that Company may link to PCP will be provided to PCP as needed. By signing this Agreement, PCP confirms that his/ her total number of Medicaid Members shall not exceed 2,500 Medicaid/CHIP lives. Non-compliance with this provision may result in sanctions,

including, but not limited to, financial sanctions, transfer of Members to another PCP within the Company or termination of this Agreement. [RFP Appendix O, #59]

4.19 Coding Requirements. Supplier shall follow Company's requirements and guidelines for Claims coding and processing that are specific to each provider type. Company shall notify Supplier ninety (90) days before implementing changes to Claims coding and processing guidelines applicable to Supplier. The State and HHS may inspect and audit any financial records of Company, Supplier or its subcontractors. There shall be no restrictions on the right of the state or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. [RFP §9.5.6]

4.20 Encounter Data. If Company has entered into any alternative reimbursement arrangement with Supplier under the terms of this Agreement, Supplier shall submit to Company all encounter data in a manner consistent with the same standards of completeness and accuracy as required for proper adjudication of FFS Claims by Company. [RFP §17.8 & Appendix O, #56]

4.21 Marketing and Member Education. Supplier agrees and understands that it is subject to and must comply with the requirements set forth in Sections 12.1-12.10 "Marketing and Member Education" of the State Contract, which shall be provided to Supplier upon request. These requirements include, but are not limited to, the review and approval of all marketing and Member materials including, but not limited to, websites, social media, ID cards, call scripts for outbound calls or customer service centers, provider directories, advertisements and direct member mailings. Supplier further agrees that it shall not steer Members to certain providers or suppliers and understands that DHH retains the discretion to deny the use of marketing and Member material that it deems to promote undue patient steering. [RFP §§12.1-12.10 & 12.20.2]

5. TERM AND TERMINATION

5.1 Termination for Failure to Re-credential. Supplier shall be subject to re-credentialing by Company during the term of this Agreement. If Supplier fails to submit all appropriate documents for re-credentialing as required under this Agreement or if Supplier's re-credentialing materials are not received by Company, this Agreement may be terminated within thirty (30) days of expiration of Supplier's current credentialing. [RFP §§14.5]

5.2 Termination for Cause. The Parties agree and understand that if this Agreement is terminated for cause, the effective date of such termination may be extended to provide adequate notice to DHH, or to otherwise comply with the requirements of the State Contract or applicable law. [RFP §§7.6.3.3 & 7.11]

5.3 Immediate Termination. Company may terminate this Agreement immediately at any time upon the following events:

(a) Supplier's actions or the actions of Supplier's subcontractor(s) pose a serious threat to the health of Members enrolled with Company; [RFP §25.53]
(b) In the event DHH determines that Company has become financially unstable and terminates the State Contract between Company and DHH; [RFP §25.54] and
(c) Supplier fails to disclose any ownership changes within thirty-five (35) calendar days as required by 42 C.F.R. § 455.104 or violates any provision therein. [RFP §25.55]

5.4 Termination Without Cause. Either Party may terminate this Agreement without cause by providing ninety (90) days advance written notice to the other Party; however, such shorter periods as applicable under state law and/or the Bayou Health Program to Supplier, where Supplier is not a group or hospital. [RFP §25.52]

6. GENERAL PROVISIONS

6.1 Disputes. Company and Supplier shall be responsible for resolving any disputes that may arise between the Parties. Any claim or controversy arising out the Agreement shall be resolved by the provisions of La. R.S. 36:1524-26. The Parties agree that no dispute shall disrupt or interfere with the provisions of services to Members. In the event DHH should prevail in any legal action arising out of the performance or non-performance by Supplier, Supplier shall pay, in addition to any monetary penalties, all expenses of such action including reasonable attorney's

fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity. [RFP §§25.4, 25.8 & Appendix O, #43]

6.2 No Assignment. Supplier shall not assign any of its duties and/or responsibilities under this Agreement and the State Contract without the prior written consent of MCO. [RFP §22.6 & Appendix O, #48]

6.3 Incorporation of Changes to Laws and Regulations. This Agreement incorporates by reference all applicable federal and state laws or regulations, and revisions of such laws or regulations shall automatically be incorporated into this Agreement as they become effective. In the event that these changes or the result of such revisions to applicable federal or state law materially affect the position of either Party, Company and Supplier agree to negotiate such further amendments as may be necessary to correct any inequities. [RFP Appendix O, #40]

6.4 Modifications and Amendments. No modification, alteration, variation, waiver, extension of termination date, early termination of this Agreement or change of any provision of this Agreement shall be made unless such modification is reduced to writing, duly signed and attached as a written amendment to this Agreement; however, Company may provide amendments by written notification through Company bulletins, if mutually agreed to by the Parties and with prior notice to DHH. [RFP §25.1]

If the modification or change constitutes a Material Change affecting Company's ability to deliver or administer health care services, prior approval is required by DHH of at least thirty (30) days in advance of the proposed change implementation. Notwithstanding the foregoing, the Parties acknowledge that this Agreement has been executed based upon a draft of the State Contract and related materials and that the provisions of such documents may be revised prior to the Effective Date. This Agreement shall be automatically amended to conform to the terms and provisions of the final State Contract and related materials. In the event of any inconsistency between the terms of this Agreement and the terms of the final requirements for provider agreements as set forth in the final State Contract and related materials, the terms of the final State Contract and the Policies shall control and take precedence. [RFP §7.13.5 & Appendix O, #6-7 & 41]

6.5 Entire Agreement. This Agreement, including the State Contract, any DHH guidance or materials, schedules, appendices, exhibits and/or addenda (which may be provided upon request), constitutes the complete and sole contract, and all terms and conditions, 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. [RFP §2.3.2, 25.18, 25.27, 25.29, & Appendix O, #5]

6.6 Non-Discrimination. Supplier and Company agree that no person, on the grounds of handicap, age, race, color, religion, sex, sexual orientation, national origin or basis of health status or need for health care services shall be excluded from participation in, or be denied benefits of the Government Program administered by Company. Supplier shall post notices of non-discrimination in conspicuous places, available to all employees and applicants. [RFP §§ 12.13.3.6 & 25.2.2]

6.7 Indemnification and Hold Harmless. Unless Supplier is a state agency, Supplier shall indemnify, defend, protect and hold harmless DHH and any of its officers, agents and employees from: [RFP §25.24]

(a) Any claims for damages or losses arising from services rendered by any contractor, person or firm performing or supplying services, materials or supplies for Supplier in connection with the performance of this Agreement;

(b) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by Supplier, its agents, officers, employees or contractors in the performance of this Agreement;

(c) Any claims for damages or losses resulting to any person or firm injured or damaged by Supplier, its agents, officers, employees, or contractors by Supplier's publication, translation, reproduction, delivery, performance, use or disposition of any data processed under this Agreement in a manner not authorized by this Agreement or by federal or state regulations or statutes;

(d) Any failure of Supplier, its agents, officers, employees or contractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;

(e) Any claims for damages, losses or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims or damages specified above; and

(f) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or their agents, officers or employees, through the intentional conduct, negligence or omission of Supplier, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of Supplier, Company or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither Supplier, Company, DHH or contractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services; provided, however, that so long as this Agreement remains in full force and effect, Supplier shall be liable for the Covered Services required to be provided or arranged for in accordance with this Agreement.

DHH will provide prompt notice of any claim against it that is subject to indemnification by Supplier under this Agreement. Supplier may, at its sole option, assume the defense of any such claim. DHH may not settle any claim subject to indemnification hereunder without the advance written consent of Supplier, which shall not be unreasonably withheld. [RFP §25.24 & Appendix O, #37]

6.8 Conflict of Interest. Supplier may not contract with Company unless such safeguards at least equal to federal safeguards (41 U.S.C. 423) are in place per the state Medicaid director letter dated December 30, 1997 and 1932 (d)(3) of the Social Security Act addressing the 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option. [RFP §25.7 & Appendix O, #44]

6.9 Severability. If any provision or requirement of this Agreement, including items incorporated by reference, is determined by DHH to conflict with the State Contract between DHH and Company, such requirement shall be null and void and all other provisions shall remain in full force and effect. In addition, if the laws or regulations governing the State Contract should be amended or judicially interpreted as to render fulfillment of the State Contract impossible or economically infeasible, such that Company is discharged from its obligations under the State Contract, Supplier shall also be discharged from further obligations created under the terms of this Agreement. [RFP §25.50 & Appendix O, #10]

6.10 Non Exclusive Clause. Nothing in this Agreement shall be construed to prohibit Supplier from entering into a contract or arrangement with any other health plan or managed care entity. Nor shall anything in this Agreement be construed to prohibit Company from entering into a contract or arrangement with any other provider. Company shall not advertise or otherwise hold itself out as having an exclusive relationship with Supplier or any service provider. [RFP §7.13.1 & Appendix O, #53 & 60-61]

6.11 Contract Language Interpretation. Subject to Section 25.31 of the RFP, Supplier agrees that in the event of a disagreement regarding, arising out of, or related to, the State Contract language interpretation, DHH's interpretation of the contract language in dispute shall control and govern. [RFP§ 25.9]

6.12 Copyrights. If any copyrightable material is developed in the course of or under the State Contract, DHH shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for DHH purposes. [RFP §25.11]

6.13 Misuse of Symbols, Emblems, or Names in Reference to Medicaid. No person or MCO may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from DHH. Specific written authorization from DHH is required to reproduce, reprint, or distribute any DHH form, application, or publication for a fee. State and local

governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or DHH terms does not provide a defense. Each piece of mail or information constitutes a violation. [RFP §25.33]

6.14 Governing Law. Notwithstanding any provision contained within the Agreement, services provided under the Bayou Health program shall be governed by the laws of the state of Louisiana, except its conflict of laws provisions, as to both interpretation and performance. Any administrative proceeding, action at law, suit in equity, or judicial proceeding brought by Supplier against DHH shall be instituted only in the administrative tribunals and courts of the state of Louisiana. Specifically, any state court suit shall be filed in the 19th Judicial District Court for East Baton Rouge Parish as the exclusive venue for same, and any federal suit shall be filed in the U.S. District Court for the Middle District of Louisiana as the exclusive venue for same. [RFP §25.21]

6.15 Offer of Gratuities. By signing the Agreement, Supplier signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the state of Louisiana, the Government Accountability Office, DHHS, CMS, or any other federal agency has or shall benefit financially or materially from the State Contract. The Agreement may be terminated by Company or DHH if it is determined that gratuities of any kind were offered to, or received by, any officials or employees from the state, its agents, or employees. [RFP §25.37]

6.16 Political Activity. None of the funds, materials, property, or services provided directly or indirectly under the Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act". [RFP §25.40]

6.17 Restrictions on Supplier's Contract and Employment Relationships. In accordance with Section 2.2, Supplier acknowledges that Company is prohibited from employing, contracting with or making payment to any individual, or any entity owned by or employing an individual, who has been excluded from participation in the Medicare and/or Medicaid programs or who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activities. Supplier agrees and understands that Company must screen, on an ongoing basis, all current, potential and temporary employees and subcontractors to determine compliance with participation in federal health care programs. In the event Company pays any unallowable funds to Supplier or other individual or entity subject to these restrictions, the full amount of unallowable funds shall be refunded to or obtained by Company or DHH. [RFP §4.1.2]

6.18 Removal/Reassignment. Supplier agrees and understands that, upon written request from DHH, Company shall be permitted to remove or reassign, or require that Supplier remove or reassign, any employee or subcontractor of Supplier that DHH deems unacceptable, including temporary employees and contractors of Supplier. Supplier, subcontractors and employees shall hold Company harmless for such actions. [RFP §4.1.6]

6.19 Required Approval of Major Subcontracts. Company is required to submit all Major Subcontracts, excluding provider subcontracts, for the provision of any services under the State Contract to DHH for prior review and approval. Supplier agrees and understands that DHH shall have the right to review and approve or disapprove any subcontracts entered into by Company for the provision of any services under the State Contract. Per the State Contract, "Major Subcontracts" are defined as any contract, subcontract or agreement between Company and another entity that meets any of the following criteria: [RFP §7.13.4]

(a) The other entity is an affiliate of Company; or
(b) The subcontract is considered by DHH to be for a key type of service or function, including:
   i. Administrative services (including, but not limited to, third-party administrators, network administration and claims processing);
   ii. Delegated networks;
   iii. Management services;
   iv. Reinsurance;
   v. Disease management;
   vi. Call lines (including nurse and medical consultation); or
   vii. Any other contract that is, or is reasonably expected to be, more than $100,000 per year. Any contracts split into separate agreements by time period or otherwise will be consolidated.

Notwithstanding the foregoing, Major Subcontracts with non-affiliates of Company for utilities, mail/shipping, office space or computer hardware are not subject to prior approval by DHH, regardless of the value of the contract.

6.20 Independent Supplier. It is expressly agreed that Supplier, and any subcontractors, agents, officers and employees of Supplier engaged in the performance of services under this Agreement, shall act in an independent capacity and not as officers, agents, express or implied, or employees of DHH or the State of Louisiana. It is further expressly agreed that this Agreement shall not be construed as a partnership or joint venture between Supplier and DHH and the State of Louisiana. [RFP §25.28]

7. DELEGATION AND DELEGATED SUBCONTRACTOR REQUIREMENTS

7.1 Delegation. Supplier shall not enter into any subsequent agreements with subcontractors for any of the work contemplated under this Agreement without Company's prior approval. In the event that duties are delegated hereunder, Company shall: [RFP Appendix O, #9]

(a) Along with Supplier, oversee all of subcontractor's performance for delegated activities;
(b) Ensure, along with Supplier (if applicable), that subcontracts fulfill the requirements of 42 C.F.R. Part 438, as appropriate to the delegated activities;
(c) Have the right to review, approve and/or disapprove or any and all subcontracts entered into for the provision of services hereunder;
(d) Evaluate, in its discretion, subcontractor's ability to perform the activities to be delegated;
(e) Require a written agreement with subcontractor, specifying the activities and reporting responsibilities delegated to subcontractor, including revocation of or imposition of sanctions for subcontractor's inadequate performance;
(f) Identify areas of deficiencies or improvement and take corrective action; and
(g) Deny payments for provider preventable conditions, per the State Contract.

7.2 Credentialing. If applicable, this Agreement shall set forth a written description of the delegation of credentialing activities delegated to subcontractor. The subcontractor must provide assurance, at all times during this Agreement, that all medical professionals are credentialed in accordance with DHH's credentialing requirements. The Parties and subcontractor understand that DHH shall have final approval over a delegated entity. The Parties agree that subcontractor shall:

(a) Load provider files into its Claims processing system within thirty (30) calendar days of receipt;
(b) Notify Company immediately if a provider credentialing application is denied for reasons related to program integrity or otherwise limits the ability of a provider to participate;
(c) Process re-credentialing not less than once every three (3) years;
(d) Adopt policies or implement Company's policies and procedures to approve, terminate or suspend providers to ensure compliance with this Agreement and the State Contract; and
(e) Implement and/or assist with a provider dispute or appeal process.

Supplier agrees and understands that, pursuant to the State Contract, DHH and/or the State of Louisiana or its representative, reserved the right to contract with a single Credential Verification Organization ("CVO") under the State Contract. In such event, Supplier and/or subcontractor agree that this Agreement shall be terminated concurrent with the minimum notice of ninety (90) days as provided to Company by DHH of such implementation of any CVO contract. [RFP §14.5]

7.3 Claims Audits. Supplier agrees and understands that subcontractors and delegated entities are subject to the audit and inspection requirements and the requirements for the adjudication of Claims under the State Contract. The cost of the audit shall be borne by Supplier. [RFP §17.11.2.5]

7.4 Pharmacy Services and Pharmacy Benefit Managers ("PBMs"). "Pharmacy Services" are defined as the provision of pharmacy benefits under the State Contract, including the dispensing of prescription drugs by pharmacies and the third-party administration of drug programs by a PBM. [RFP §5.14]

7.4.1 With respect to Pharmacy Services, including the provision of goods and services related to the provision of Pharmacy Services, Supplier agrees to comply with all applicable laws, rules, including any rules and guidance issued by the LSBME, DHH, or other state or federal agency.

7.4.2 Supplier agrees and understands that Company is required under the State Contract to disclose to DHH all financial terms and arrangements for remuneration of any kind that apply between Company and Company's pharmacy supplier, other subcontractor, prescription drug wholesaler, manufacturer or labeler. Such information may include, but is not limited to, formulary management, educational support, claims processing, pharmacy network fees, drug product sales, pricing agreements, data sales fees, and any other fees. Pursuant to the State Contract, Supplier shall disclose any such financial terms and arrangements for remuneration to Company. DHH or state auditors may audit such information at any time. DHH agrees to maintain the confidentiality of information disclosed by Company to the extent that such information is confidential under state and/or federal law. [RFP §5.14]

7.4.3 Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription.

7.4.4 Supplier agrees and understands that Members must have free access to any pharmacy participating in Company's network (except in cases where the member is participating in the pharmacy lock-in program).

7.4.5 Company and Supplier are prohibited from displaying the names and/or logos of co-branded Pharmacy Services on Member identification cards. In the event Company and Supplier agree to any co-branding initiatives, all marketing materials (other than ID cards) must clearly state that other pharmacies are available to Member in Company's network. Supplier acknowledges and understands that any co-branded materials must be submitted to DHH for prior approval.

7.4.6 Supplier shall cooperate with Company and provide Company with information necessary to meet all reporting requirements for Pharmacy Services, including, but not limited to:

(a) Pharmacy help desk performance;
(b) Prior authorization performance;
(c) Prior authorization request turnaround time;
(d) Number of claims submitted as a 72 hour emergency supply;
(e) Denials (name of drug, number of requests, number of denials);
(f) Pharmacy network access;
(g) Grievance and appeals; and
(h) Medication therapy management initiatives.

Louisiana State Compliance Addendum

This Louisiana State Compliance Addendum (the "State Compliance Addendum") is incorporated by reference in the Agreement. This State Compliance Addendum shall supplement the Addendum and control, unless such provision conflicts with the State Contract or Louisiana Department of Health and Hospitals' ("DHH") rules and regulations.

For purposes of this State Compliance Addendum, the term "Supplier" shall mean the individual or entity executing the Agreement, and may include a health care physician, provider, group, facility, hospital, individual or entity. Capitalized terms used in this State Compliance Addendum that are not defined herein shall have the meaning set forth in the Addendum and/or the main Agreement.

1.0 SUPPLIER SERVICES AND OBLIGATIONS

1.1 Non-compliant Members. If Supplier desires to discharge a Member, Supplier shall follow the rules and Policies of Company. Supplier agrees to continue to provide Covered Services to such Member under the same terms and conditions as set forth in this Agreement until such time as Company makes appropriate arrangements for another Participating Provider to accept such Member as a patient.

1.2 Emergency Management Plan. When applicable, Supplier agrees to become familiar with and abide by the terms and procedures set forth in Company's emergency or catastrophe response, management or operations plan as required and approved by DHH, Louisiana Department of Insurance ("LDI") or other governmental body, including, but not limited to, the execution of a memorandum of understanding with Company if Supplier is located in a parish where services may be provided to evacuated Members, when required by Company. Supplier acknowledges and understands that said plan is confidential and the Proprietary Information of Company. This provision shall survive termination of this Agreement. La. R.S. 22:572.

2.0 COMPANY OBLIGATIONS

2.1 No Interference by Company. Company agrees that it will not prohibit or restrict Supplier from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of Company which may negatively impact upon the quality of, or access to patient care in accordance with state and federal law. La. R.S. 22:1007; 42 C.F.R. § 438.102(a)(1)(i)-(iv).

2.2 Open Communication with Members. Nothing in this Agreement shall be construed to impede the open clinical dialogue and clinical communication between Supplier and Members or otherwise interfere with Supplier's ability to communicate with a Member regarding his or her health care, including but not limited to communications regarding treatment options, medical alternatives or other coverage arrangements. Company encourages Supplier to freely communicate with Members about clinical treatment options, including medications, available to them, regardless of benefit coverage limitations. Notwithstanding the foregoing, Supplier shall not solicit for alternative coverage arrangements for the primary purpose of securing financial gain. La. R.S. 22:1007(B).

2.3 Required Disclosures by Company. To ensure that Company does not have any "silent PPO" arrangements, Company shall disclose within forty-five (45) days following the written request of Supplier:

(a) The list of clients or other payors entitled to a contracted rate under Company's contract with Supplier; and

(b) The specific clients or other payors by whom a contracted rate was applied to a particular claim under Company's contract with Supplier.

La. R.S. 40:2203.1.

2.4 Communication of Plan and Health Benefit Program Changes. In order to prevent or reduce the risk of misinformation, Supplier agrees that Company shall have the exclusive right and responsibility to communicate changes in the Plan or other health benefit programs to Members. It is understood, however, that this shall not be

interpreted as restricting in any way Supplier's ability to freely communicate medical advice to Members, and shall not be construed as prohibiting any communication subject to the protections of La. R.S. 22:1007.

3.0 CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Compensation; Reimbursement Rates. The payments rendered or to be rendered to Suppliers under this Agreement, as may be amended from time to time, shall be deemed and shall remain confidential information. This provision shall survive any termination of this Agreement. La. R.S. 22:263(F).

3.2 Prohibited Inducements. Nothing in this Agreement shall be construed to provide an incentive or specific payment from Company, directly, indirectly or in any form, to Supplier as an inducement to deny, reduce, limit or delay Medically Necessary and appropriate services provided with respect to a specific Member or group of Members with similar medical conditions. La. R.S. 22:263(E); La. R.S. 22:1008.

4.0 TERM AND TERMINATION

4.1 Continuity of Care. In the event this Agreement is terminated, Supplier shall notify Company of any Member who has begun a course of treatment by Supplier before the effective date of the termination. Upon such notice, Company shall notify the Member of the termination of Supplier from Company's network and the Member's right to continuity of care. Upon termination of this Agreement, the following provisions shall apply:

(a) In the event Member has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth (24th) week of pregnancy, Member shall be allowed to continue receiving Covered Services, subject to the consent of Supplier, through delivery and postpartum care related to the pregnancy and delivery.

(b) In the event a Member has been diagnosed with a life-threatening illness (a severe, serious or acute condition for which death is probable), Member shall be allowed to continue receiving Covered Services, subject to the consent of Supplier, until the course of treatment is completed, not to exceed three (3) months from the effective date of such termination.

(c) In the event Supplier advises Company of a Member who meets the criteria of the foregoing paragraphs, Company shall continue payment to Supplier at the rate that was in effect prior to the termination of this Agreement. In addition, the contractual requirements for Supplier to follow Company's utilization management and quality management policies and procedures, when applicable, shall remain in effect for the applicable period described above.

(d) Supplier shall be prohibited from discount billing and dual billing as prohibited by the Louisiana Health Care Consumer Billing and Disclosure Protection Act (La. R.S. 22:1871 *et seq.*); however, Supplier shall be deemed to be a contracted Supplier with Company for payment purposes for services provided pursuant to this Section.

La. R.S. 22:1005(B).

4.2 Continuity of Care; Exceptions. Notwithstanding the foregoing, the continuity of care provisions above shall not apply when:

(a) The reason for such termination is due to suspension, revocation, or applicable restriction of the Supplier's license to practice in this state by the Louisiana State Board of Medical Examiners or for another documented reason related to quality of care;

(b) The Member chooses to change Suppliers;

(c) The Member moves out of the geographic service area of the health care provider or health insurance issuer; and

(d) The Member requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

La. R.S. 22:1005(C).

5.0 DISPUTE RESOLUTION

5.1 Grievance Procedure. A grievance procedure has been established for the processing of any Member complaints regarding Covered Services furnished by Supplier. Supplier shall comply with and, subject to Supplier's rights of appeal, shall be bound by such grievance procedure. In addition, Supplier shall adhere to all appeal/expedited appeal procedures for Medicare and/or Medicaid beneficiaries, including the gathering and forwarding of information on appeals to the Company, as necessary. La. R.S. 22:263(A)(3).

5.2 Assistance with Member Grievance Dispute Resolution. When required by Company or applicable law, Supplier shall display notices of a Member's right to appeal any adverse action affecting Covered Services in public areas of Supplier's facility(ies). Upon request from Supplier, Company shall furnish Supplier with additional copies of public notices and appeal forms. At Supplier's discretion, Supplier may file a grievance on behalf of a Member; however, Supplier shall adhere to the requirements and grievance and appeals procedures outlined by Company, CMS, DHH or other governmental body. Notwithstanding any Company, CMS or DHH grievance and appeal process, rule or contractual provision to the contrary, Supplier is not precluded from pursuing relief through a court of appropriate jurisdiction for the resolution of a provider initiated grievance or appeal. With respect to emergency appeals and when appropriate, Supplier shall comply with all appeal processes and shall assist Members by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for Company and/or state level review. La. R.S. 22:267.

Exhibit A.8

Individual Sites Regulatory Compliance Addendum (Virginia)

PROGRAM PARTICIPATION SCHEDULE

Delegated Entity agrees to participate in the Plans and other health benefit programs listed herein:

- Those publicly funded managed care programs for Medicaid, CHIP or other low-income individuals offered by Company within the State of Virginia.
- Those Medicare plans for Medicaid enrollees offered by Company within the State of Virginia. Includes Medicare D-SNP and integrated Medicare-Medicaid Plans.
- Those Qualified Health Plans, whether purchased on the exchange or in the private market, offered by Company within the State of Virginia.

Individual Sites Regulatory Compliance Addendum – Exhibit A.9

VIRGINIA MEDICAID COMPLIANCE ADDENDUM – SUBCONTRACTOR

This Medicaid Compliance Addendum is incorporated by reference in the Agreement. If there is any conflict between the terms of this Addendum and any of the terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, that if there is any conflict between any of the terms of the Agreement, including this Addendum, and the applicable State Contract, then the terms of the applicable State Contract will govern and control.

For purposes of this Addendum, the term "Subcontractor" shall mean a State approved entity that contracts with Company to perform part of the Company's responsibilities under the applicable State Contract. For the purposes of this Addendum and the Agreement, Subcontractor's providers shall also be considered providers of the Company. In the event that any of the following required Medicaid provisions are inapplicable to Subcontractor, as construed under the applicable State Contract and in accordance with Applicable Laws, such provision shall not apply.

Company and Subcontractor agree to abide by all applicable provisions of the applicable State Contract. Subcontractor compliance with the applicable State Contract specifically includes, but is not limited to, the requirements contained herein.

1.0 DEFINITIONS

All capitalized terms in this Addendum shall have the meaning set forth in the Agreement unless otherwise defined herein, in which case the definitions contained in this Addendum shall control.

1.1 Applicable Law. All federal or state laws, rules, regulations, and administrative agency directives applicable to the Medicaid program and to Medicaid managed care plans, as these may be amended from time to time, including, but not limited to, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kickbacks. Applicable Laws include the Centers for Medicare and Medicaid Services' ("CMS") and the Virginia Department of Medical Assistance Services' ("DMAS" or the "Department") instructions, policy letters or guidelines that regulate the actions of Subcontractor or Company, requirements of the State Plan, as applicable, and requirements of the applicable State Contract. The "State Plan" is the State Plan for Medical Assistance, submitted to CMS by DMAS describing the nature and scope of the Virginia Medicaid program. DMAS has the authority to administer the State Plan under Code of Virginia § 32.1-325.

1.2 Medically Necessary or Medical Necessity. Appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 CFR § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. For children under age 21, medical necessity review must fully consider Federal EPSDT guidelines for Medallion 3.0 enrollees. EPSDT is not applicable to FAMIS. (*Medallion 3.0 Contract, Section 1.1; FAMIS Contract, Section 1.1*)

2.0 REGULATORY AND CONTRACTUAL REQUIREMENTS FOR MEDALLION 3.0 AND FAMIS

2.1 Compliance. Subcontractor agrees to maintain documentation of its compliance with 12VAC5-408 et seq., the Agreement, and any and all Applicable Laws. (*12VAC5-408-320(C)*)

2.2 Access to Facilities and Records. Subcontractor shall provide for timely and efficient access by state examiners to data, records, and personnel necessary to determine compliance with 12VAC5-408 et seq. (*12VAC5-408-320(E)*)

2.3 Subcontractor Disclosures. Subcontractor agrees to disclose the required information, at the time of application, credentialing, and/or recredentialing, in accordance with 42 CFR § 455 Subpart B and relevant provisions of the applicable State Contract, as related to ownership and control, business transactions, and criminal

conviction for offenses against Medicare, Medicaid, CHIP and/or Federal health care programs. See 42 CFR § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs. Subcontractor shall perform, at a minimum, a monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with these Federal regulations. (*Medallion 3.0 Contract, Section 3.4.A, Section 13.3.A.I.c, and Section 13.3.A.II.c(v)-(vi); FAMIS Contract, Section 3.4.A, Section 13.3.A.I.c, and Section 13.3.A.II.c(v)-(vi)*)

2.4 License and Certification. Subcontractor represents and warrants that it is licensed by the Commonwealth of Virginia and has received proper certification or training to perform the specific services for which it is contracted. (*Medallion 3.0 Contract, Section 3.16; FAMIS Contract, Section 3.16*)

2.5 Delegation Requirements.

2.5.1 Subcontractor acknowledges and agrees that the Agreement fulfills the requirements of the applicable State Contract and all Applicable Laws, including, but not limited to, the requirement to specify the activities and reporting responsibilities delegated to Subcontractor. (*Medallion 3.0 Contract, Section 3.16.A.I.b and 3.16.A.I.c; FAMIS Contract, Section 3.16.A.I.b and 3.16.A.I.c*)

2.5.2 Subcontractor acknowledges and agrees that the Department may evaluate through inspection or other means, the quality, appropriateness, and timeliness of the services performed under the Agreement. (*Medallion 3.0 Contract, Section 3.16.A.I.d; FAMIS Contract, Section 3.16.A.I.d*)

2.5.3 Subcontractor shall comply with Member privacy protections described in Health Insurance Portability and Accountability Act regulations and in Title 45 CFR parts 160 and 164, subparts A and E. (*Medallion 3.0 Contract, Section 3.16.A.I.e; FAMIS Contract, Section 3.16.A.I.e*)

2.5.4 Company may revoke the delegation of services to Subcontractor under the Agreement, or impose sanctions on Subcontractor, in the event Subcontractor's performance under the Agreement is inadequate. Subcontractor shall promptly supply to Company all information necessary for the reimbursement of any outstanding Medicaid claims. (*Medallion 3.0 Contract, Section 3.16.A.I.f; FAMIS Contract, Section 3.16.A.I.f*)

2.6 Monitoring Requirements.

2.6.1 Subcontractor shall permit Company to perform on-going monitoring of Subcontractor in order to assure compliance with the requirements set forth in the Agreement. (*Medallion 3.0 Contract, Section 3.16.A.II.a; FAMIS Contract, Section 3.16.A.II.a*)

2.6.2 Company shall perform a formal performance review of Subcontractor at least annually. (*Medallion 3.0 Contract, Section 3.16.A.II.b; FAMIS Contract, Section 3.16.A.II.b*)

2.6.3 If applicable, Company shall monitor encounter data of Subcontractor before the data is submitted to the Department. Company shall apply certain key edits to the data to ensure accuracy and completeness. These edits shall include, but not be limited to, member and provider identification numbers, dates of service, diagnosis and procedure codes, etc. (*Medallion 3.0 Contract, Section 3.16.A.II.c; FAMIS Contract, Section 3.16.A.II.c*)

2.6.4 Company shall monitor Subcontractor's provider enrollment, credentialing, and recredentialing policies and procedures to assure compliance with Federal disclosure requirements described in the applicable State Contract, with respect to disclosure of information regarding ownership and control, business transactions, and criminal convictions for crimes against Federally funded or Federally related health care programs. Additionally, Company shall monitor to assure that Subcontractor complies with requirements for prohibited affiliations with individuals or entities excluded from participation in Federally related health care programs as described in the applicable State Contract. (*Medallion 3.0 Contract, Section 3.16.A.II.d; FAMIS Contract, Section 3.16.A.II.d*)

2.6.1 As a result of monitoring activities conducted by the Company (through on-going monitoring and/or annual review), the Company shall identify to Subcontractor deficiencies or areas for improvement, and the

Subcontractor shall take appropriate corrective action. (*Medallion 3.0 Contract, Section 3.16.A.II.e; FAMIS Contract, Section 3.16.A.II.e*)

2.7 Review Requirements. Subcontractor acknowledges and agrees that this Addendum and the Agreement are subject to the Department's written approval. The Department may revoke such approval if the Department determines that Subcontractor fails to meet the requirements of the applicable State Contract. If Subcontractor is responsible for the provision of covered services, for the purposes of the applicable State Contract, Subcontractor shall be considered both a subcontractor and network provider. Company shall adhere to subcontractor specific restrictions set forth in the applicable State Contract. (*Medallion 3.0 Contract, Section 3.16.B; FAMIS Contract, Section 3.16.B*)

2.8 Utilization Management.

2.8.1 If Company has delegated responsibilities for utilization management to Subcontractor, Subcontractor is prohibited from providing compensation to utilization management staff in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member. (*Medallion 3.0 Contract, Section 7.1.P; FAMIS Contract, Section 7.1.P*)

2.8.2 If Company has delegated responsibilities for utilization management to Subcontractor, Subcontractor shall comply with all standards for utilization management as set forth in the applicable State Contract. Subcontractor acknowledges and agrees that the preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. (*Medallion 3.0 Contract, Section 7.1.P.II; FAMIS Contract, Section 7.1.P.II*)

2.9 Subcontractor Cooperation with Company Programs. Subcontractor agrees to cooperate with the External Quality Review Organization (EQRO), which is contracted by the Department to perform quality studies. The level of cooperation includes, but is not limited to, responding favorably and promptly to requests for Members' medical records in the format and timeframe requested by the EQRO or the Department. (*Medallion 3.0 Contract, Section 8.4; FAMIS Contract, Section 8.4*)

2.10 Audits. Company has the right to conduct routine and random audits of Subcontractor. (*Medallion 3.0 Contract, Section 9.2.G.II; FAMIS Contract, Section 9.2.G.IV*)

2.11 Hold Harmless. Subcontractor hereby agrees that in no event, including, but not limited to, nonpayment by Company or Subcontractor; the insolvency of Company; or breach of the Agreement, shall Subcontractor bill, charge, collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against Members or persons other than Company for services provided pursuant to the applicable State Contract. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of the applicable Plan. Subcontractor further agrees that (i) this provision shall survive the termination of the Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Plan's Members and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Subcontractor and any Member or other person acting on Member's behalf. The restrictions on billing Members as set forth herein and in the Agreement shall continue to be in effect even if Company becomes insolvent. Notwithstanding the foregoing, if a Member agrees in advance of receiving a service and in writing to pay for a service that is not a State Plan Covered Service, then Company, directly or through Subcontractor, can bill the Member for the service. (*Virginia Code § 38.2-5805(C)(9) and (10); 14VAC5-211-30(C); Medallion 3.0 Contract, Section 12.9 and Attachment III; FAMIS Contract, Section 12.9 and Attachment III, Section A.13*)

2.12 Billing Members for Medically Necessary Services.

2.12.1 Subcontractor is subject to criminal penalties if providers knowingly and willfully charge, for any service provided to a Member under the State Plan or under the applicable State Contract, money or other consideration at a rate in excess of the rate established by the Department, as specified in Section 1128B (d)(1) of the Social Security Act (42 U.S.C. § 1320a-7b), as amended. This provision shall continue to be in effect even if the Company becomes insolvent until such time as Members are withdrawn from assignment to the Company.

(Medallion 3.0 Contract, Section 12.9.A; FAMIS Contract, Section 12.9.A)

2.12.2 Pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), Subcontractor shall not hold a Member liable for (i) debts of the Company in the event of the Company's insolvency; (ii) payment for services provided by Company if Company has not received payment from the Department for the services or if the provider, under contract or other arrangement with Company, fails to receive payment from the Department or Company; (iii) payments to providers that furnish covered services under a contract or other arrangement with Company that are in excess of the amount that normally would be paid by the Member if the service had been received directly from Company. *(Medallion 3.0 Contract, Section 12.9.A.I, II, and III; FAMIS Contract, Section 12.9.A.I, II, and III)*

2.13 Bonuses and Incentive Payments. Company shall not provide bonus and/or incentive payments to Subcontractor which are determined based upon the applicability of the contract provision specified in Section 12.11 of the applicable State Contract. *(Medallion 3.0 Contract, Section 12.11; FAMIS Contract, Section 12.11)*

2.14 Prohibited Actions.

2.14.1 Subcontractor may not knowingly have a relationship of a type described in Section 2.14.2 with (i) an individual or entity who is debarred, suspended, or otherwise excluded from participating in Federal health care programs, as listed on the federal List of Excluded Individuals/ Entities (LEIE) database at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or (ii) an individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in clause (i). Subcontractor is further prohibited from contracting with providers who have been terminated from the Medicaid or FAMIS programs by DMAS for fraud, waste and abuse. *(Medallion 3.0 Contract, Section 13.3.A.I.a(i) and (ii) and 13.3.C.I; FAMIS Contract, Section 13.3.A.I.a(i) and (ii) and Section 13.3.C.I)*

2.14.2 The relationships described in this section are as follows: (i) a director, officer, or partner of the Company; (ii) a person with beneficial ownership of five percent or more of Company's equity; or (iii) a person with an employment, consulting or other arrangement with Company for the provision of items and services that are significant and material to Company's obligations under the applicable State Contract with the Department. *(Medallion 3.0 Contract, Section 13.3.A.I.b(i), (ii), and (iii); FAMIS Contract, Section 13.3.A.I.b(i), (ii), and (iii))*

2.14.3 Subcontractor shall immediately report to Company any exclusion information discovered on the LEIE database. *(Medallion 3.0 Contract, Section 13.3.C.II; FAMIS Contract, Section 13.3.C.II)*

2.14.4 Subcontractor shall maintain written policies and procedures outlining provider enrollment and/or credentialing process. *(Medallion 3.0 Contract, Section 13.3.C.II; FAMIS Contract, Section 13.3.C.II)*

2.15 Protected Health Information. If Subcontractor receives or has access to protected health information ("PHI"), Subcontractor shall sign an agreement with Company that complies with the Health Insurance Portability and Accountability Act, and Subcontractor hereby agrees to be bound by the restrictions, terms, and conditions relating to PHI that apply to Company in the applicable State Contract. *(Medallion 3.0 Contract, Section 13.5.A, 13.5.B, 13.5.B.III, and 14.19.B; FAMIS Contract, Section 13.5A, 13.5.B, 13.5.B.III, and 14.19.B)*

2.16 Access to Facilities and Records. Subcontractor shall allow duly authorized agents or representatives of the State or Federal Government, including, but not limited to, the Department, during normal business hours, access to its premises to inspect, audit, monitor or otherwise evaluate the performance of Subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested, Subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Subcontractor's activities. All information so obtained will be accorded confidential treatment as provided under Applicable Law. The Department and its duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of Subcontractor and shall be allowed to inspect, copy, and audit any medical and/or financial records of Subcontractor. *(Medallion 3.0*

Contract, Section 14.1 and 14.19.B.I; FAMIS Contract, Section 14.1 and 14.19.B.I.)

2.17 Worker's Compensation. Subcontractor shall obtain and maintain, for the duration of this Agreement, workers' compensation insurance for all its employees working in the Commonwealth. (*Medallion 3.0 Contract, Section 14.16.B; FAMIS Contract, Section 14.16.B*)

2.18 Medical Records. Subcontractor shall comply with the security and confidentiality of records standards as detailed in the applicable State Contract. (*Medallion 3.0 Contract, Section 14.19; FAMIS Contract, Section 14.19*)

2.19 Subcontractor Bankruptcy. Subcontractor shall notify Company of any bankruptcy filing on or before the date of such filing. (*Medallion 3.0 Contract, Section 14.29.B.VI; FAMIS Contract, Section 14.29.B.VI*)

3.0 STATUTORY AND REGULATORY REQUIREMENTS FOR MANAGED CARE PLANS

3.1 Termination. If Subcontractor terminates the Agreement, Subcontractor shall give Company at least 60 days' advance notice of termination. In addition, Subcontractor shall ensure that any agreement to provide health care services between Subcontractor and a health care provider requires the provider to give at least 60 days' advance notice of termination of such agreement to Subcontractor. (*Virginia Code § 38.2-5805(C)(6) and (C)(7)*)

4.0 REGULATORY REQUIREMENTS SPECIFIC TO MEDALLION 3.0 MANAGED CARE PLANS

4.1 Requests for Service. Subcontractor shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of service, when applicable under the Agreement. (*12VAC30-120-380(H)*)

Exhibit B

Company Affiliates
Including all products listed in Exhibit A

Affiliate Name	Address	City	State	Zip
Aetna Better Health Inc. dba Aetna Better Health of Illinois	333 W Wacker Drive, Suite 2100	Chicago	Illinois	60606
Aetna Better Health, Inc. dba Aetna Better Health of Louisiana	2400 Veterans Memorial Blvd., Suite 200	Kenner	Louisiana	70062
Aetna Better Health of Michigan Inc.	1333 Gratiot Ave, Suite 400	Detroit	Michigan	48207
Aetna Better Health of Missouri LLC	10 South Broadway #1200	St. Louis	Missouri	63102
Aetna Better Health Inc. dba Aetna Better Health of Ohio	7400 West Campus Drive	New Albany	Ohio	43054
Aetna Better Health Inc. dba Aetna Better Health of Pennsylvania	2000 Market St., Suite 850	Philadelphia	Pennsylvania	19103
Aetna Health Inc. dba Aetna Better Health Kids	2000 Market St., Suite 850	Philadelphia	Pennsylvania	19103
Aetna Better Health of Kentucky Insurance Company	9900 Corporate Campus Drive, Suite 1000	Louisville	Kentucky	40223
Coventry Health Care of Virginia, Inc. dba CoventryCares of Virginia	9881 Mayland Drive	Richmond	Virginia	23233

EIGHTH AMENDMENT TO THE
RADIOLOGY MANAGEMENT SERVICES AGREEMENT

This Amendment ("Amendment") is dated February 11, 2016, and is between **Aetna Medicaid Administrators LLC**, on behalf of itself and its Affiliates ("Company"), and **MedSolutions, Inc.**, d/b/a eviCore healthcare, a Tennessee corporation with its principal place of business in Franklin, TN ("Delegated Entity").

WHEREAS, Company and Delegated Entity entered into a Radiology Management Services Agreement dated January 1, 2014 ("Agreement") for the provision of Utilization Management services;

WHEREAS, Company and Delegated Entity have since amended the Agreement on or around the following dates: First Amendment on April 1, 2014 (Musculoskeletal Pain Management); Second Amendment on April 1, 2014 (adding Maryland and Pennsylvania Regulatory Addenda); Third Amendment was never executed and is intentionally omitted; Fourth Amendment on July 16, 2014 (adding Missouri and Michigan); Fifth Amendment originally executed on May 1, 2015 and re-executed on October 19, 2015 (adding Louisiana); Sixth Amendment on May 1, 2015 (revising Musculoskeletal Pain Management Rates and adding Ohio Regulatory Addendum); Seventh Amendment on December 15, 2015 (restating compensation, updating compliance addenda for Michigan and Louisiana, adding Kentucky and Virginia); and

WHEREAS, Company and Delegated Entity desire to update Exhibit 2: Compensation Schedule to include non-OB ultrasound rates for Missouri effective October 1, 2015.

NOW, THEREFORE, in consideration of the mutual covenants and promises stated herein and other good and valuable consideration, and intending to be legally bound, Company and Delegated Entity agree as follows:

1. The Agreement's Exhibit 2: Compensation Schedule is hereby deleted in its entirety and replaced with the attached Exhibit 2: Compensation Schedule, specifically to add a row to Missouri for Ultrasound – Non OB. The Parties agree that the rates for the Missouri Ultrasound – Non OB took effect October 1, 2015.

2. Capitalized terms not otherwise defined herein shall have the meaning ascribed to them in the Agreement.

3. All other terms and provisions of the Agreement not amended herein shall remain in full force and effect, without modification.

4. The Parties ratify and affirm the Agreement, and agree that it is in full force and effect as amended herein. In the event of any inconsistency between the terms of this Amendment and the Agreement, the terms of this Amendment shall govern and control.

IN WITNESS WHEREOF, the Parties have caused this Amendment to be signed by their duly authorized officers as of the ~~date indicated~~ in the introductory clause.

MEDSOLUTIONS, INC.

Signature

Alan Loenitsce
Printed Name

CFO: Radiology, Cardiology, MSC
Title

2/26/16
Date

Tax I.D. #: 62-1615395

NPI #: 1992077762

Medicaid #: N/A

Medicare #: N/A

AETNA MEDICAID ADMINISTRATORS LLC

Signature

Robert M. Kessler
Printed Name

Secretary
Title

March 8, 2016
Date

Exhibit 2: Compensation Schedule

The Administrative Fees by Member type and modality are listed in the following tables by state.

		[redacted]
Arizona	Advanced Imaging	
	Pain Management	
Illinois	Advanced Imaging	
	Pain Management	
Louisiana (effective 10/19/15)	Advanced Imaging	
	Pain Management	
Maryland	Advanced Imaging	
	Ultrasound – Non OB	
Missouri	Advanced Imaging	
	Ultrasound – OB Only	
	Ultrasound – Non OB (effective 10/1/15)	
Michigan	Advanced Imaging	
Ohio	Advanced Imaging	
	Ultrasound – Non OB	
	Pain Management	
Pennsylvania	Advanced Imaging	
	Ultrasound – Non OB	
	Pain Management	
Texas	Advanced Imaging	

- Advanced Imaging includes management of MRI, MRA, CT, CTA and PET
- Cardiology includes management of Nuclear Cardiology, Heart Catheterization, Stress Echo, TTE, and TEE
- Ultrasound includes management of OB and non-OB ultrasound, if the plan's TANF ultrasound utilization is below [redacted]

Enhanced Clinical Quality Review

With regard to Kentucky and Virginia, Company and Delegated Entity agree to pursue and implement an enhanced clinical quality review for Advanced Imaging ("Clinical Quality Review Services") for certain Members. The Administrative Fees by Member type and modality are listed in the following table by state:

State	Modality	TANF	CHIP	ABD	Medicaid Expansion <+18	Medicaid Expansion Adult
Kentucky (effective 2/01/2016)	Advanced Imaging	[redacted]				
	Ultrasound					
	Ultrasound – OB					
	Ultrasound – Non OB					
	Pain Management					
Virginia (effective 4/01/2016)	Advanced Imaging					
	Cardiology					
	Ultrasound OB only					
	Ultrasound Non-OB					
	Pain Management					

The Clinical Quality Review Services include enhanced review of Advanced Imaging Prior Authorization requests as follows:

1. Medical Necessity certifications, including alternative recommendations where appropriate, in accordance with evidenced based guidelines and Company's Clinical Policy Bulletin (CPB).
2. At least [redacted] (or as adjusted based on changes in clinical review effectiveness to achieve enhanced compliance with evidence based guidelines, as agreed to by the Parties) of precertification requests shall be subject to Nurse and/or Medical Director review to include determinations for compliance with evidenced based guidelines.

Each month, Delegated Entity shall charge Company an Administrative Fee for the provision of Delegated Entity Program Services. The monthly Administrative Fee shall be equal to the aggregate of the applicable per Member per month amounts set forth in the table below:

1. **Payment.** On or before the 15th day of each month, Company shall prepay Delegated Entity an Administrative Fee for the provision of Delegated Entity Program services.

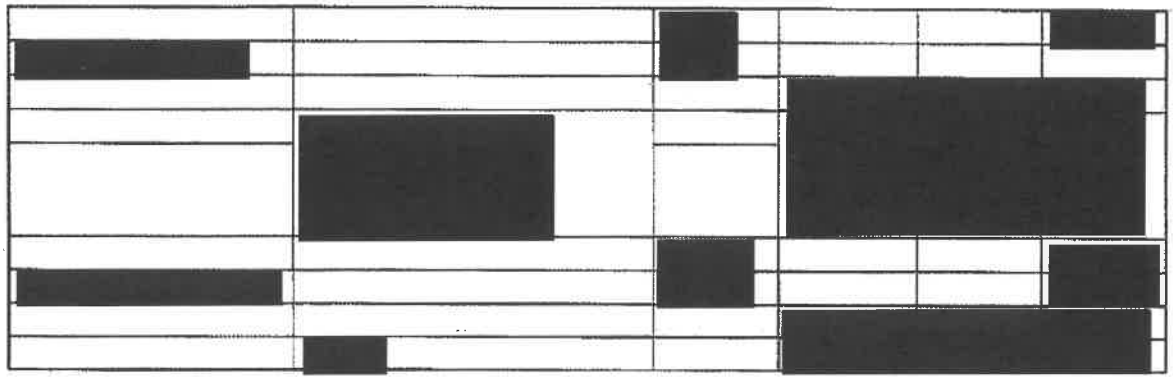
a) If a Member is added to Company Membership on or before the 15th day of a month, a full month's Administrative Fee will be due for that month. There will be no Administrative Fee due for Member added after the 15th day of the month.

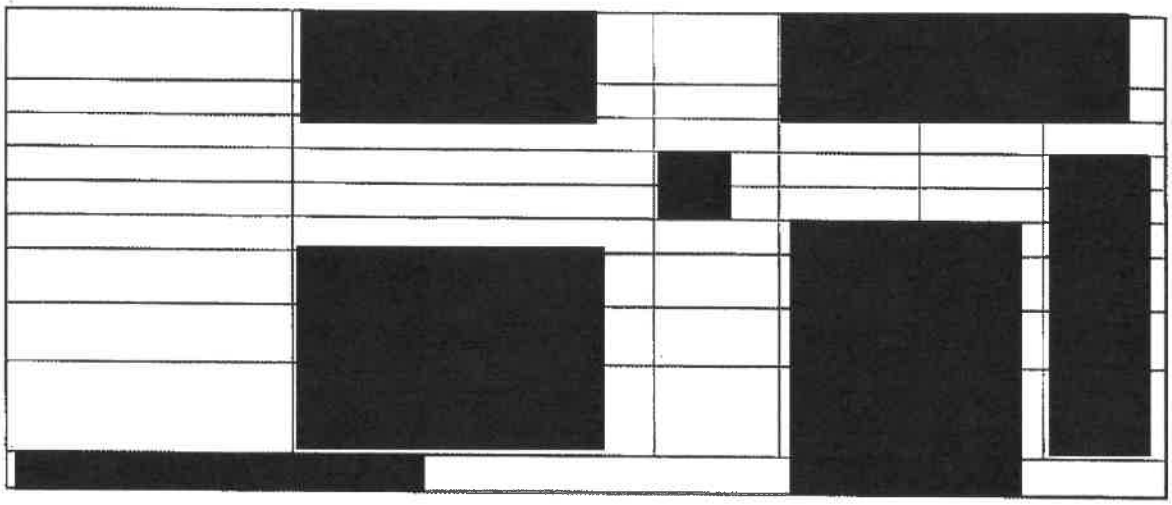
b) A full month's Administrative Fee will be due for the month of termination of a Member if the Member terminates after the 15th day of the month. If a Member terminates on or before the 15th day of a month, no Administrative Fee will be due for the month of termination.

2. **Adjustments.** Where Company, due to information delays, must make a retroactive addition or deletion to Delegated Entity's membership records, a retroactive adjustment shall be made concurrent therewith and such retroactive Administrative Fee adjustments shall not exceed sixty (60) days for each single Member. With the exception of any fraud investigation, the limit to the period of time in which Delegated Entity or Company can make a claim of an overpayment or underpayment or contest an underpayment or overpayment under this Agreement is one hundred eighty (180) days from the date the payment was made or one hundred eighty (180) days from the date of final adjudication.

The Administrative Payment. Amounts otherwise due to Delegated Entity shall be reduced as follows for Delegated Entity's failure to meet the Performance Guarantees set forth in Exhibit 3.

1. For failure to meet any of the satisfaction measures set forth in Exhibit 3, Section B.1 for the previous calendar year, [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous year, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee
2. For failure to meet any of the call center measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.2: [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous month, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.
3. For failure to meet the pre-certification turn-around-time and Adverse Determination overturn measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.3: [redacted] of the annualized Administrative Payment Amounts (excluding the Sleep Administrative Services Fee) payable by Company during the previous quarter, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.
4. For failure to meet the pre-certification turn-around-time overturn measures for the Sleep Program when averaged for the calendar year measured as set forth in Exhibit 3, Section B.4: [redacted] of the annualized Sleep Administrative Services Fee payable by Company during the previous quarter.
5. Example. Delegated Entity performance results are measured after the Program Year has been completed. Those results become published ninety (90) days at the completion of the Program Year. The results at end of the Program Year show the following:





6. Implementation Costs. Delegated Entity shall pay Company the actual costs incurred by Company, but no more than [redacted] towards Company's implementation costs of the radiology management program ("Implementation Fee"). Delegated Entity shall pay a first installment of [redacted] of the Implementation Fee no later than 15 days after this Agreement's signature. Delegated Entity shall pay second and subsequent installments of the Implementation Fee, if needed, each year thereafter.

NINTH AMENDMENT TO THE
RADIOLOGY MANAGEMENT SERVICES AGREEMENT

This Amendment ("Amendment") is dated April 1, 2016, and is between Aetna Medicaid Administrators LLC, on behalf of itself and its Affiliates ("Company"); and MedSolutions, Inc., a Tennessee corporation with its principal place of business in Franklin, TN ("Delegated Entity").

WHEREAS, Company and Delegated Entity entered into a Radiology Management Services Agreement on January 1, 2014 ("Agreement") for the provision of Utilization Management services;

WHEREAS, Company and Delegated Entity have since amended the Agreement on or around the following dates: First Amendment April 1, 2014 (Musculoskeletal Pain Management); Second Amendment on April 1, 2014 (adding Maryland and Pennsylvania Regulatory Addenda); and Third Amendments were never executed and is intentionally omitted; Fourth Amendment July 16, 2014 (adding Missouri and Michigan); Fifth Amendment May 1, 2015 and re-executed on October 19th, 2015 (adding Louisiana); Sixth Amendment May 1, 2015 (revising Musculoskeletal Pain Management rates and adding Ohio Regulatory Addendum); Seventh Amendment, December 15, 2015 (restating compensation, updating compliance addenda for Michigan and Louisiana, adding Kentucky and Virginia; Eight Amendment, February 11, 2016 (restating compensation, adding Missouri for Ultrasound – Non OB for an effective date of October 1, 2015); and

WHEREAS, Company and Delegated Entity desire to amend the Agreement to include Aetna Better Health, Inc., dba Aetna Better Health of New Jersey, and update Exhibit 2: Compensation Schedule; and to amend Individual Site Regulatory Compliance Addendum for Aetna Better Health of Illinois, Aetna Better Health of Texas; and all compensation and terms associated with this addition

NOW, THEREFORE, in consideration of the mutual covenants and promises stated herein and in the Agreement, and other good and valuable consideration, Company and Delegated Entity agree as follows:

1. The Agreement's Exhibit 2: Compensation Schedule is hereby deleted in its entirety and replaced with the attached Exhibit 2: Compensation Schedule, specifically to add New Jersey; and Texas for ultrasound previously omitted; and to update Kentucky for ultrasound; and Virginia for ultrasound and Advanced Imaging rates; and

2. The Agreement's Individual Sites Regulatory Compliance Addendum (Exhibit A) is hereby updated with the updated Regulatory Compliance Addendum.

   Individual Sites Regulatory Compliance Addendum (Illinois) Governing Medicaid CHIP Services for Aetna Better Health of Illinois; and

   Individual Sites Regulatory Compliance Addendum (Illinois) Governing Medicare-Medicaid Dual-Eligible Services for Aetna Better Health of Illinois; and

   Individual Sites Regulatory Compliance Addendum (Texas) Governing Medicaid CHIP Service for Aetna Better Health of Texas; and

   Individual Sites Regulatory Compliance Addendum (New Jersey) Governing Medicaid CHIP Services for Aetna Better Health of New Jersey; and

   Individual Sites Regulatory Compliance Addendum (Virginia) Governing Medicaid Services for Aetna Better Health of Virginia; and

1. The Agreement's Exhibit B: Company Affiliates is hereby deleted in its entirety and replaced with the following Exhibit B Company Affiliates; and

2. All other terms and provisions of the Agreement not amended herein shall remain in full force and effect, without modification.

3. The Parties ratify and affirm the Agreement, and agree that it is in full force and effect as amended herein. In the event of any inconsistency between the terms of this Amendment and the Agreement, the terms of this Amendment shall govern and control.

WITNESS WHEREOF, the Parties have caused this Amendment to be signed by their duly authorized officers as of the date indicated in the introductory clause.

MEDSOLUTIONS, INC.

By: _____

Printed Name: Alan Pochatko

Title: Chief Accounting Officer

Date: 4.21.16

AETNA MEDICAID ADMINISTRATORS LLC

By: _____

Printed Name: Robert M. Kessler

Title: Secretary

Date: April 27, 2016

Exhibit 2:
COMPENSATION SCHEDULE

This Compensation Schedule shall be governed by and construed in accordance with the terms and conditions of the Radiology Management Services Agreement (the "Agreement") entered into by and between Aetna Medicaid Administrators LLC and Delegated Entity. The rates described in this Exhibit 2 are payable to Affiliate beginning on the Effective Dates listed in the table below. .

Administrative Payment Amount.

The Administrative Fees by member type and modality are listed in the following table.

General Rate Summary.

Modality	TANF	CHIP	ABD	LTSS	Duals	Other	SNP - dual
Advanced Imaging	[redacted]						
Cardiology							
Ultrasound Ultrasound OB only Ultrasound Non-OB							
Pain Management							

- Advanced Imaging includes management of MRI, MRA, CT, CTA and PET
- Cardiology includes management of Nuclear Cardiology, Heart Cauterization, Stress Echo, TTE, and TEE)
- Ultrasound includes management of OB and non-OB ultrasound, if the plan's TANF ultrasound utilization is below [redacted]

The Administrative Fees by state are listed in the tables below.

State (Effective Date)	Modality	TANF	CHIP	ABD	LTSS	Duals
Arizona (effective 11.01.2014)	Advanced Imaging	[redacted]				
Illinois (effective 03.09.2015)	Advanced Imaging					
	Pain Management					
Louisiana (effective 10.19.15)	Advanced Imaging					
Maryland (effective 04.01.2014)	Advanced Imaging					
	Ultrasound – Non OB					
Missouri (effective 10.01.2014)	Advanced Imaging					
	Ultrasound – OB only					
	Ultrasound – Non OB (effective 10.01.2015)					
	Pain Management					

Michigan (effective 11.01.2014)	Advanced Imaging	[redacted]
New Jersey (effective 07.11.2016)	Advance Imaging	
	Cardiology	
	Ultrasound	
	Pain Management	
Ohio (effective 03.09.2015)	Advanced Imaging	
	Ultrasound – Non OB	
	Pain Management	
Pennsylvania (effective 03.01.2014)	Advanced Imaging	
	Ultrasound – Non OB	
	Pain Management	
Texas (effective 09.01.2015)	Advanced Imaging	
	Ultrasound	

KENTUCKY AND VIRGINIA HIGH TOUCH ASO PRODUCT

Enhanced Clinical Quality Review

With regard to Kentucky and Virginia, Company and Delegated Entity agree to pursue and implement an enhanced clinical quality review for Advanced Imaging ("Clinical Quality Review Services") for certain Members. The Administrative Fees by Member type and modality are listed in the following table by state:

State (Effective Date)	Modality	CANC	CHIP	ABD	Medicaid Expansion <=1E	Medicaid Expansion Adult
Kentucky (effective 02.01.2016)	Advanced Imaging	[redacted]				
	Ultrasound					
	Pain Management					
Virginia (effective 04/01/2016)	Advanced Imaging					
	Ultrasound					
	Pain Management					

The Clinical Quality Review Services include enhance review of Advance Imaging Prior Authorization requests as follows:

1. Medical Necessity certifications, including alternative recommendations where appropriate, in accordance with evidenced based guidelines and Company's Clinical Policy Bulletin (CPB)

2. At least [redacted] (or as adjusted based on changes in clinical review effectiveness to achieve enhanced compliance with evidence based guidelines, as agreed to by the Parties) of precertification requests shall be subject to Nurse and/or Medical Director review to include determinations for compliance with evidenced based guidelines.

Each month, Delegated Entity shall charge Company an Administrative Fee for the provision of Delegated Entity Program Services. The monthly Administrative Fee shall be equal to the aggregate of the applicable per Member per month amounts set forth in the table below:

1) Payment. On or before the 15th day of each month, Company shall prepay Delegated Entity an "Administrative Fee" for provision of Delegated Entity Program services.

a) If a Member is added to Company Membership on or before the 15th day of a month, a full month's Service Fee will be due for that month. There will be no Administrative Fee due for Members added after the 15th day of the month.

b) A full month's Administrative Fee will be due for the month of termination of a Member if the Member terminates after the 15th day of the month. If a Member terminates on or before the 15th day of a month, no Administrative Fee will be due for the month of termination.

2) Adjustments. Where Company due to information delays, must make a retroactive addition or deletion to Delegated Entity's membership records, a retroactive adjustment shall be made concurrent therewith and such retroactive Administrative Fee adjustments shall not exceed sixty (60) days for each single Member. With the exception of any fraud investigation the limit to the period of time in which Delegated Entity or Company can make a claim of an overpayment or underpayment or contest an underpayment or overpayment under this Agreement is one hundred eighty (180) days from the date of the payment was made or one hundred eighty (180) days from the date of final adjudication.

The Administrative Payment. Amounts otherwise due to Delegated Entity shall be reduced as follows for Delegated Entity's failure to meet the Performance Guarantees set forth in Exhibit 3.

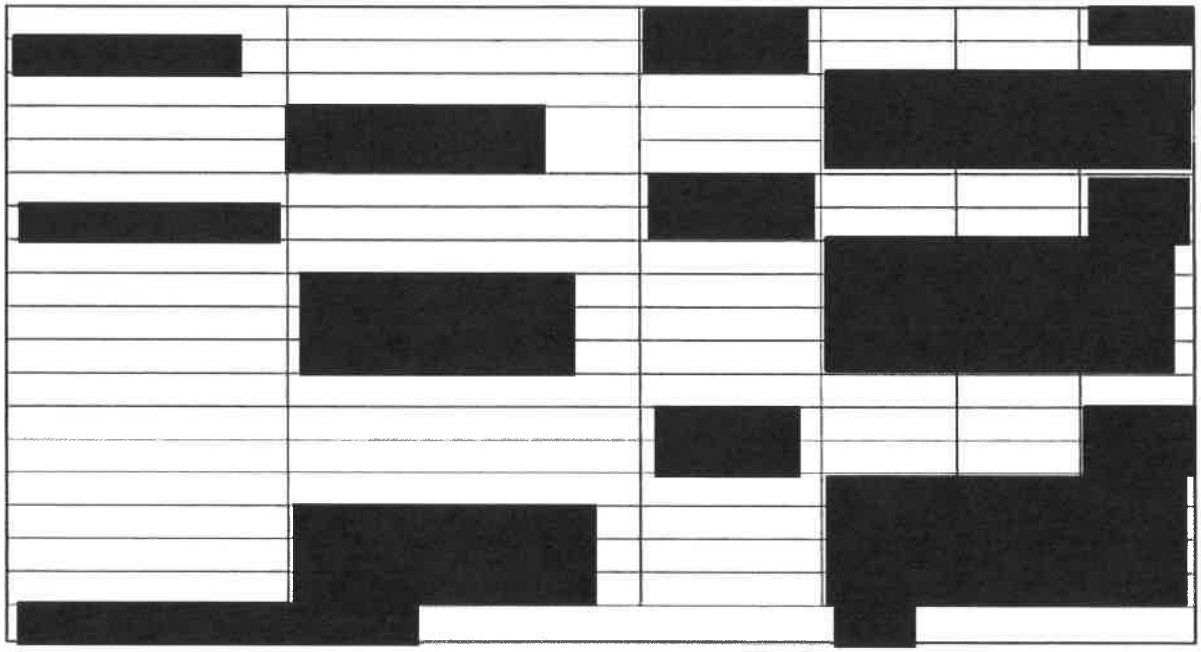
1. For failure to meet any of the satisfaction measures set forth in Exhibit 3, Section B.1 for the previous calendar year, [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous year, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

2. For failure to meet any of the call center measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.2: [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous month, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

3. For failure to meet the pre-certification turn-around-time and Adverse Determination overturn measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.3: [redacted] of the annualized Administrative Payment Amounts (excluding the Sleep Administrative Services Fee) payable by Company during the previous quarter, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

4. For failure to meet the pre-certification turn-around-time overturn measures for the Sleep Program when averaged for the calendar year measured as set forth in Exhibit 3, Section B.4: [redacted] of the annualized Sleep Administrative Services Fee payable by Company during the previous quarter.

5. Example. Delegated Entity performance results are measured after the Program Year has been completed. Those results become published ninety (90) days at the completion of the Program Year. The results at end of the Program Year show the following:



6. Implementation Costs. Delegated Entity shall pay Company the actual costs incurred by Company, but no more than [redacted] towards Company's implementation costs of the radiology management program ("Implementation Fee"). Delegated Entity shall pay a first installment of [redacted] of the Implementation Fee no later than 15 days after this Agreement's signature. Delegated Entity shall pay second and subsequent installments of the Implementation Fee, if needed, each year thereafter.

Individual Sites Regulatory Addendum – Exhibit A
Regulatory Compliance Addendum

Governing Illinois Medicaid Services

This Regulatory Compliance Addendum Governing Illinois Medicaid Services (the "Illinois Medicaid Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under, as well as the provision of any administrative or health-benefit management services/functions that relate to, as applicable:

(1) the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health Inc., an Illinois Corporation, for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization*, Contract No. 2015-24-004 (ABH) f/k/a Contract No. 2010-24-005-K, effective on or about May 1, 2011, which governs the program known as the Illinois Integrated Care Program a/k/a the ICP (the "ICP Contract"); and/or

(2) the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health for Furnishing Health Services by a Managed Care Organization*, Contract No. 2015-24-002, effective on or about August 1, 2014, which governs the program known as the Illinois Family Health Plan Population–Affordable Care Act Adult program a/k/a FHP-ACA program (the "FHP-ACA Contract").

Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois ("Company") serves as a managed-care organization under both the ICP Contract and the FHP-ACA Contract (the "State Contracts") on behalf of the State of Illinois and its Department for Healthcare and Family Services ("HFS" and collectively, the "State").

The State requires that specific terms and conditions be incorporated into the Agreement. As such, this Illinois Medicaid Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof), and such provider, vendor, contractor, or other entity must comply with the requirements set forth herein. Note that this Illinois Medicaid Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in the policies, procedures, and provider manual of Company (or its Affiliate, as the case may be). This Illinois Medicaid Addendum and the Agreement may be revised as directed by the State.

For purposes of this Illinois Medicaid Addendum, the individuals who are enrolled with Company under the State Contracts will be referred to as the "Enrollees." All capitalized terms not defined in this Illinois Medicaid Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Illinois Medicaid Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Illinois Medicaid Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contracts and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contracts. Except as provided herein, all other provisions of the Agreement not inconsistent with this Illinois Medicaid Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Illinois Medicaid Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The provider, vendor, contractor, or other entity identified on the first page of the Agreement acknowledges and agrees that all provisions of this Illinois Medicaid Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members who are eligible and covered under the State Contracts, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the State Contracts, and it/they represent and warrant that it/they shall take all steps

necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Illinois Medicaid Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

A. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this Illinois Medicaid Addendum:

a. "Authorized Persons" – Collectively means HFS, HFS's Office of Inspector General ("HFS OIG"), the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, the United States Department of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS"), and any other State or federal agencies with monitoring authority related to Medicaid. [ICP Contract § 1.19; FHP-ACA Contract § 1.20]

b. "Provider" – Means any individual or entity that is enrolled with the State to provide Covered Services to Enrollees and that is associated with Company pursuant to a written contract or agreement for the purpose of providing health care services under the State Contracts. [ICP Contract §§ 1.16, 1.118; FHP-ACA Contract §§ 1.16, 1.17, 1.122]

c. "Subcontractor" – Means any individual or entity, other than a Provider, with which Company has entered into a written agreement for the purpose of delegating responsibilities applicable to Company under the State Contracts. [ICP Contract § 1.144; FHP-ACA Contract § 1.148]

B. Requirements Applicable to State Contracts and Covered Services

1. **Practice Coverage and Hours; Enrollee Appointments. Provider agrees to provide Covered Services to Enrollees as set forth in the Agreement, including without limitation the following when such Covered Services are specified in the Agreement:**

a. Primary care providers (PCPs) and specialty Providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after-hours telephone number (after-hours voicemail alone is not acceptable). [ICP Contract § 5.6.4; FHP-ACA Contract § 5.7.4]

b. Provider shall offer to Enrollees hours of operation that are no less than the hours of operation offered to persons who are not Enrollees. [ICP Contract § 5.6.3; FHP-ACA Contract § 5.7.3]

c. Provider shall ensure that time-specific appointments for routine, preventive care to an Enrollee are available within five (5) weeks from the date of request for such care, and within two (2) weeks from the date of request for infants under age six (6) months. If an Enrollee has more serious problems that are not deemed emergency medical conditions, Provider shall triage that Enrollee and, if necessary or appropriate, immediately refer that Enrollee for urgent medically necessary care or provide that Enrollee with an appointment within one (1) business day of the request. If an Enrollee has a problem or complaint that is not deemed serious, Provider shall see that Enrollee within three (3) weeks from the date of request for such care. If Enrollee seeks an initial prenatal visit without expressed problems, the Provider shall see that Enrollee within two (2) weeks after a request if the Enrollee is in her first trimester, within one (1) week if the Enrollee is in her second trimester, and within three (3) days if the Enrollee is in her third trimester. [ICP Contract § 5.6.3; FHP-ACA Contract § 5.7.3]

2. **Payments; Hold Harmless of Enrollees/State.**

a. Provider/Subcontractor acknowledges and agrees that Company shall not pay a Provider/Subcontractor for any provider-preventable condition. Provider/Subcontractor shall report all provider-preventable conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made. [FHP-ACA Contract § 5.25.8]

b. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state plan or waiver.

c. Except as permitted or required by HFS in 89 Ill. Adm. Code 125, in HFS's fee-for-service copayment policy in effect at the time Covered Services are provided, and/or in the State Contracts, neither Company nor Provider/Subcontractor may seek or obtain funding through fees or charges to any Enrollee receiving Covered Services under the State Contracts. Provider/Subcontractor furthermore acknowledges and agrees that imposing charges in excess of those permitted under the State Contracts is a violation of Section 1128B(d) of the Social Security Act and subjects the party imposing such charges to criminal penalties. [ICP Contract § 5.30; FHP-ACA Contract § 5.30]

d. Provider/Subcontractor agrees that in no event, including but not limited to the nonpayment by Company of amounts due to Provider/Subcontractor under the Agreement, the insolvency of Company, or any breach of the Agreement by Company, shall Provider/Subcontractor or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against the Enrollee or persons acting on the Enrollee's behalf (other than Company) for services provided pursuant to the Agreement except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Enrollees and all persons acting on the Enrollees' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider/Subcontractor and the Enrollee or persons acting on the Enrollee's behalf (other than Company). [215 ILCS 125/2-8(a)]

e. Any dispute between Company and Provider/Subcontractor shall be solely between those parties, and Company and Provider/Subcontractor shall each hold harmless the State and its agencies, officers, employees, agents, and volunteers from and against such dispute and any and all liabilities, demands, claims, suits, losses, damages, causes of action, fines, or judgments, including costs, attorneys' and witnesses' fees, and expenses incident thereto, regardless of the reason. [ICP Contract §§ 7.13, 9.1.8, 9.1.28; FHP-ACA Contract §§ 7.13, 9.1.8, 9.1.28]

3. **Standards of Care. In addition to complying with other applicable standards of care, Provider/Subcontractor shall:**

a. Timely identify any Enrollees with high-risk pregnancies and arrange for a maternal fetal medicine specialist or a transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements for referral and/or transfer of high-risk women. [ICP Contract, Attachment XXI ¶ 3.c.i.D; FHP-ACA Contract, Attachment XXI ¶ 3.c.i.D]

b. Cooperate and communicate with other service providers who serve Enrollees, including without limitation Special Supplemental Nutrition Programs for Women, Infants, and Children (commonly referred to as "WIC" programs); Head Start programs; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the Enrollee). [ICP Contract, Attachment XXI ¶ 3.e.i.; FHP-ACA Contract, Attachment XXI ¶ 3.e.i.]

4. **Cultural Competence; Prohibition on Discrimination. In addition to complying with other applicable standards:**

a. Provider/Subcontractor shall cooperate in the implementation of, and comply with all requirements set forth in, Company's Cultural Competence Plan, which shall include implementation of the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). Provider/Subcontractor acknowledges and agrees that all Covered Services shall be provided in a culturally competent manner by ensuring the cultural competence of all Provider/Subcontractor staff, from clerical to executive management. Furthermore, Subcontractors shall complete Company's initial and annual cultural-competence training. [ICP Contract §§ 2.7, 2.7.3, 2.7.4; FHP-ACA Contract §§ 2.7, 2.7.3, 2.7.4]

b. Provider/Subcontractor shall abide by all federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Illinois Human Rights Act, and Executive Orders 11246 and 11375. Provider/Subcontractor furthermore agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Agreement. Provider/Subcontractor will furthermore not discriminate against Enrollees or prospective or potential Enrollees on the basis of health status, need for health services, or payment source. All Provider/Subcontractor locations where Enrollees receive Covered Services shall comply with the Americans with Disabilities Act of 1990. [77 Ill. Admin. Code § 240.50(d)(4); ICP Contract §§ 2.8, 5.6.2, 9.1.22; FHP-ACA Contract §§ 2.8, 5.7.2, 9.1.22]

5. Anti-Gag Clause; Prohibition on Retaliation. Provider/Subcontractor shall not be prohibited or otherwise restricted or discouraged from, and shall not prohibit or otherwise restrict or discourage its downstream providers or subcontractors from, taking any of the following actions so long as those actions are within the lawful scope of the acting party's practice: (a) advocating for medically appropriate health care services for Enrollees, which may include without limitation appealing denials and protesting decisions, policies, and practices; (b) advising an Enrollee about the health status of that Enrollee or medical care or treatment for that Enrollee's condition or disease regardless of whether benefits for such care or treatment are provided under the Agreement and/or the State Contracts; and/or (c) discussing with Enrollees, prospective Enrollees, or the public any health care services, health care providers, utilization review policies, quality assurance policies, or terms and conditions of plans and plan policy. Furthermore, Company shall not retaliate against Provider/Subcontractor, and Provider/Subcontractor shall not retaliate against its downstream providers or subcontractors, for any of the foregoing actions. Notwithstanding the foregoing, nothing in this provision shall be construed to prohibit: (a) Company or Provider/Subcontractor from making a determination not to pay for a particular health care service, from enforcing reasonable peer review or utilization review protocols, or from determining whether a physician or other health care provider has complied with those protocols; and/or (b) a Provider that is a hospital from taking disciplinary actions against a physician as authorized by law. [215 ILCS 134/30(a); 215 ILCS 134/35(a)-(d); ICP Contract § 5.32; FHP-ACA Contract § 5.32]

6. **Grievances and Appeals. Provider/Subcontractor shall comply with Company's grievance and appeal processes referenced in the Agreement, and Company shall notify Provider/Subcontractor within fifteen (15) days following any substantive change to such procedures. [ICP Contract § 5.28.6; FHP-ACA Contract § 5.28.6]**

7. **Data and Reporting.**

a. Provider/Subcontractor shall submit all data, reports, and clinical information required by Company under the State Contracts in such manner and format, and pursuant to such timeframes, as requested by Company and/or HFS. Provider/Subcontractor shall ensure that all data and reports that it submits to Company are accurate and complete, and Provider/Subcontractor furthermore acknowledges and agrees that all such data and reports shall be available to HFS and, upon request, to federal CMS. [ICP Contract § 5.24; FHP-ACA Contract § 5.24]

b. If Provider/Subcontractor provides Covered Services to Enrollees under a Illinois Department of Human Services ("DHS") Home and Community-Based Services ("HCBS") Waiver, under the Medicaid Clinic Option, or under the Medicaid Rehabilitation Option, or provides subacute alcoholism and substance-abuse

treatment services pursuant to 89 Ill. Admin. Code §§ 148.340–148.390 and 77 Ill. Admin. Code Part 2090, such Provider/Subcontractor shall enter any data regarding Enrollees that is required under State rules, or under a contract between the Provider/Subcontractor and DHS, into any subsystem maintained by DHS, including, but not limited to, DHS's Automated Reporting and Tracking System (DARTS). [FHP-ACA Contract § 5.28.1.3]

8. **Delegation. If Company delegates to Provider/Subcontractor any activities or obligations under the State Contracts:**

a. Company shall remain ultimately responsible for the performance of those responsibilities and nothing in the Agreement shall be construed to terminate Company's legal responsibility to DHS to assure that all activities under the State Contracts are carried out. [ICP Contract §§ 5.28.2, 5.28.3; FHP-ACA Contract §§ 5.28.2, 5.28.3]

b. Provider/Subcontractor acknowledges and agrees that Company's delegated oversight committee will oversee Provider/Subcontractor's activities and performance under the Agreement to ensure compliance with all applicable contractual and statutory requirements, including without limitation the Illinois Human Rights Act, the U.S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act. Company's oversight of Provider/Subcontractor will include, without limitation: pre-delegation audits; quarterly delegation oversight reviews of delegate performance; monthly joint-operation meetings; annual audits of Provider/Subcontractor; regular monitoring of Enrollee complaints with respect to Provider/Subcontractor; and documentation of issues and development of a corrective action plan, as warranted, to improve performance. [ICP Contract § 2.7.4; FHP-ACA Contract § 2.7.4]

c. To the extent that such delegated activities are credentialing or recredentialing activities or obligations under the State Contracts, Provider/Subcontractor shall maintain a formal credentialing program and shall conduct all such activities or obligations in compliance with Company, National Committee for Quality Assurance (NCQA), and State standards. Company shall monitor such credentialing/recredentialing delegated activities and shall review Provider/Subcontractor's credentialing files no less than annually as part of the annual audit. [ICP Contract § 5.7.4, Attachment XI ¶ 7.e.; FHP-ACA Contract § 5.8.4, Attachment XI ¶ 7.e.]

9. **Quality Assurance. With respect to Company's quality-assurance obligations under the State Contracts:**

a. Provider/Subcontractor shall participate in and cooperate with Company's quality-assurance program (QAP), shall cooperate with Company with respect to Company's QAP obligations under the State Contracts, and shall cooperate with Company's quality improvement committee. Provider/Subcontractor shall furthermore allow Company to access Provider/Subcontractor's Enrollee medical records to permit effective quality review. [ICP Contract, Attachment XI ¶ 6.b.; FHP-ACA Contract, Attachment XI ¶ 6.b.]

b. Provider/Subcontractor shall provide, arrange for, or participate in the quality-assurance programs mandated by the Illinois Health Maintenance Organization Act, unless the Illinois Department of Public Health has certified that such programs will be fully implemented without any participation or action from Provider/Subcontractor. [215 ILCS 125/2-8(a); 50 Ill. Admin. Code § 5241.50(a)(4)]

c. Provider/Subcontractor acknowledges and agrees that Company shall perform quality-assurance evaluations of Provider/Subcontractor's practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. [ICP Contract § 2.7.5; FHP-ACA Contract § 2.7.5]

d. Provider/Subcontractor shall cooperate and comply with all remedial or corrective actions that Company implements with respect to Provider/Subcontractor and/or its services under the Agreement, upon Company's determination that Provider/Subcontractor has furnished inappropriate or substandard services or has failed to furnish services that should have been furnished. [ICP Contract, Attachment XI ¶ 3.e., FHP-ACA Contract, Attachment XI ¶ 3.e.]

e. If Company delegates to Provider/Subcontractor any quality-assurance activities or obligations that Company has under the State Contracts:

(i) Company and Provider/Subcontractor shall agree in writing upon the delegated activities, the accountability of Provider/Subcontractor for those activities, and the frequency of Provider/Subcontractor's reporting to Company related to those activities. [ICP Contract, Attachment XI ¶ 7.a.; FHP-ACA Contract, Attachment XI ¶ 7.a.]

(ii) Company and Provider/Subcontractor shall agree in writing upon the standards and procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided. [ICP Contract, Attachment XI ¶ 7.b.; FHP-ACA Contract, Attachment XI ¶ 7.b.]

(iii) All such delegated activities shall conform to the requirements set forth in the State Contracts. [ICP Contract, Attachment XI ¶ 7.c.; FHP-ACA Contract, Attachment XI ¶ 7.c.]

(iv) Provider/Subcontractor acknowledges and agrees that Company shall engage in continuous and ongoing evaluation and oversight of such delegated activities, including approval of quality-improvement plans and regular specified reports, as well as a formal review of such activities. Company's oversight of Provider/Subcontractor's performance of these delegated activities must include no less than an annual audit, analyses of required reports and encounter data, a review of Enrollee complaints, grievances, Provider complaints, and quality of care concerns raised through encounter data, monitoring activities, or other venues. Outcomes of Company's annual audit shall be submitted to HFS as part of Company's QA/UR/PR Annual Report. [ICP Contract, Attachment XI ¶ 7.d.; FHP-ACA Contract, Attachment XI ¶ 7.d.]

(v) If Company or Provider/Subcontractor identifies areas requiring improvement, Company or Provider/Subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, Provider/Subcontractor must develop and implement a corrective action plan, with protections put in place by Company to prevent such deficiencies from recurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to HFS through quarterly or annual reporting. [ICP Contract, Attachment XI ¶ 7.f.; FHP-ACA Contract, Attachment XI ¶ 7.f.]

10. **Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy-related Covered Services:**

a. Provider/Subcontractor shall administer all pharmacy benefits in accordance with the provisions and requirements of the State Contracts and all applicable State and federal laws and regulations. [ICP Contract §§ 5.1.7, 5.16.6; FHP-ACA Contract §§ 5.2.5, 5.16.6]

b. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contracts to submit required pharmacy-related reports and data to applicable federal and State authorities. [ICP Contract, Attachment XIII; FHP-ACA Contract, Attachment XIII]

c. If Company delegates to Provider/Subcontractor any pharmacy-related activities or obligations that Company has under the State Contracts, Provider/Subcontractor shall comply with all pharmacy-related provisions and requirements set forth in the State Contracts, including without limitation the following, as applicable:

(i) Company and Provider/Subcontractor shall submit a pharmacy formulary for prior approval by the State initially and annually thereafter. [ICP Contract § 5.1.7; FHP-ACA Contract § 5.2.5]

(ii) Company and Provider/Subcontractor shall provide coverage of drugs in all classes of drugs for which HFS's fee-for-service program provides coverage. [ICP Contract § 5.1.7.1; FHP-ACA Contract § 5.2.5.1]

(iii) Company and Provider/Subcontractor shall cover only drugs made by manufacturers that participate in the federal Medicaid drug rebate program, which applies to both prescription and over-the-counter drugs, but does not apply to non-drug items such as blood sugar test strips. HFS will provide a listing of manufacturers that participate in the federal Medicaid drug rebate program. [ICP Contract § 5.1.7.2; FHP-ACA Contract § 5.2.5.2]

(iv) Company and Provider/Subcontractor may determine their own utilization controls, including without limitation step therapy and prior approval, unless otherwise prohibited under the State Contracts, to ensure appropriate utilization. Company and Provider/Subcontractor shall utilize HFS's step-therapy and prior-authorization requirements for family-planning drugs and devices as set forth in the State Contracts. [ICP Contract § 5.1.7.3; FHP-ACA Contract § 5.2.5.3]

(v) Company and Provider/Subcontractor shall ensure that they require pharmacy, medical, and hospital providers to identify 340B-purchased drugs on pharmacy, medical, and hospital claims following HFS billing guidelines applied in HFS's fee-for-service program, and Company and Provider/Subcontractor shall furthermore ensure that its encounter claims to HFS identify these drugs. [ICP Contract § 5.1.7.4; FHP-ACA Contract § 5.2.5.4] For any outpatient drugs *not* identified in accordance with the previous sentence: (i) Company and Provider/Subcontractor shall collect information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees, and (ii) Company and Provider/Subcontractor shall report to HFS quarterly, in a format and in the detail specified by HFS, information on the total number of units of each dosage form and strength and package size by National Drug Code of each such covered outpatient drug dispensed to Enrollees. [FHP-ACA Contract §§ 5.2.5.4.1, 5.2.5.4.2]

(vi) Company and Provider/Subcontractor shall establish and maintain a generic drug Maximum Allowable Cost (MAC) dispute-resolution process, subject to approval by HFS. The MAC dispute-resolution process shall enable pharmacies to report pricing disputes to the Company and/or Provider/Subcontractor up to sixty (60) days from the claim date and Company and/or Provider/Subcontractor is required to resolve the pricing dispute within twenty-one (21) days by adjusting the reimbursement rate to represent the average acquisition cost of the drug, or by informing the pharmacy of alternative generic equivalent products that can be purchased at or below the Company's existing MAC price. [ICP Contract § 5.1.7.5; FHP-ACA Contract § 5.2.5.5]

(vii) Company and Provider/Subcontractor shall develop and implement a system, including policies and procedures, coverage criteria, and processes for their Drug Utilization Review (DUR) program. The DUR program shall include a prospective review process for all drugs prior to dispensing and all non-formulary drug requests, and a retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. Company and Provider/Subcontractor are required to report prospective and retrospective DUR activities to HFS quarterly, and to assist in data collection and reporting to HFS of data necessary to complete the federal CMS DUR annual report. [ICP Contract § 5.1.7.6; FHP-ACA Contract § 5.2.5.6]

(viii) Company and Provider/Subcontractor shall comply with the pharmacy prior-authorization provisions and requirements set forth in Section 5.16.6 of each of the State Contracts, which requires that Company and/or Provider/Subcontractor must authorize or deny a prior-authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization. [ICP Contract § 5.16.6; FHP-ACA Contract § 5.16.6]

(ix) Company and Provider/Subcontractor shall not permit or allow, whether by contract, written policy, or procedure, any individual or entity to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act (codified at 410 ILCS 620/3.14). [215 ILCS 134/30(b)]

11. **Children's Mental Health Service Requirements. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to any behavioral-health Covered Services that Provider/Subcontractor provides to Enrollees under the age of twenty one (21):**

a. Provider/Subcontractor shall administer all such behavioral-health benefits in accordance with the provisions and requirements of Attachment XXII of the FHP-ACA Contract and in accordance with all applicable State and federal laws and regulations. [FHP-ACA Contract, Attachment XXII]

b. If Provider is an inpatient psychiatric Provider, it shall administer a physical examination to the Enrollee within twenty-four (24) hours after admission when that Enrollee requires admission to an appropriate inpatient institutional treatment setting. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.iv.]

c. Provider shall comply with Company's procedures with respect to discharge and transitional planning related to an appropriate inpatient institutional treatment setting, and shall cooperate with Company in the education and training of the Enrollee's family on how to use the "crisis safety plans" while the Enrollee is receiving inpatient institutional treatment. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.v.5.]

d. If Provider/Subcontractor provides Mobile Crisis Response Services in connection with the State Contracts:

(i) Provider/Subcontractor shall ensure that the staff providing those services hold the following credentials: (a) Mental Health Professional (MHP) with direct access to a Qualified Mental Health professional; (b) Qualified Mental Health Professional; or (c) Licensed Practitioner of the Healing Arts. [FHP-ACA Contract, Attachment XXII, ¶ 3.f.]

(ii) Provider/Subcontractor shall provide immediate crisis and stabilization services when an Enrollee in crisis can be stabilized in the community. [FHP-ACA Contract, Attachment XXII, ¶ 4.a.i.]

(iii) Provider/Subcontractor shall establish a "crisis safety plan" for all Enrollees presenting in behavioral-health crisis that is unique to the Enrollee and the circumstances leading to the crisis situation. [FHP-ACA Contract, Attachment XXII, ¶¶ 4.a.ii., 4.b.i.]

(iv) Provider/Subcontractor shall provide the Enrollee's family with contact information that may be used at any time, 24 hours a day, to contact Company in moments of crisis. [FHP-ACA Contract, Attachment XXII, ¶ 4.a.iv.]

(v) Provider/Subcontractor shall provide families of Enrollees with physical copies of the "crisis safety plan" (a) prior to the completion of the crisis screening event for any Enrollee stabilized in the community, and (b) prior to discharge of the Enrollee from an inpatient psychiatric hospital for any Enrollee that is admitted to such a facility. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.ii.]

(vi) Provider/Subcontractor shall educate and orient the Enrollee's family to the components of the "crisis safety plan" to ensure that the plan is reviewed with the family regularly, and to detail how the plan is updated as necessary. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.iii.]

(vii) Provider/Subcontractor shall share the "crisis safety plan" with all necessary medical professionals, including care coordinators, consistent with the authorizations established by consent or release. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.iv.]

(viii) Provider/Subcontractor shall facilitate the Enrollee's admission to an appropriate inpatient institutional treatment setting when the Enrollee in crisis cannot be stabilized in the community. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.i.]

(ix) Provider/Subcontractor shall inform the Enrollee's parents, guardian, caregivers, or residential staff about all of the available service providers and pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.ii.]

12. Third Party Liability. Provider/Subcontractor acknowledges and agrees that Medicaid payment, under the State Contracts or otherwise, is secondary to other sources of payment for Covered Services provided to Enrollees, and that Medicaid (and consequently Company, as a Medicaid MCO of the State) is the payer of last resort. Provider/Subcontractor furthermore acknowledges and agrees that when Company is aware of third-party sources of payment for Covered Services, Company is required to "cost avoid" (*i.e.*, deny) the associated claim and to redirect Provider/Subcontractor to bill that third-party source of payment as the primary payor.

13. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to submit financial and expense-related reports/data to the State relating to the risk adjustment and Medical Loss Ratio (MLR) adjustment set forth in the State Contracts. [ICP Contract §§ 7.4, 7.11; FHP-ACA Contract §§ 7.4, 7.11]

b. Company's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [ICP Contract §§ 9.1.37, 9.1.38; FHP-ACA Contract §§ 9.1.36, 9.1.37]

c. Company's obligation to provide a "medical home," as that term is used in the State Contracts, for its Enrollees. [ICP Contract §§ 5.5.7, 5.9.2; FHP-ACA Contract §§ 5.6.7, 5.9.2]

d. Company's obligation to encourage Provider/Subcontractor to support Enrollees in directing their own care and in development of the Enrollee's care plan. [ICP Contract § 5.12.6; FHP-ACA Contract § 5.14.5; 5.14.8.1.3]

e. Company's obligation to avoid unnecessary utilization of emergency services by Enrollees and to promote care management through the Enrollees' primary care providers (PCPs) or "medical home." [ICP Contract § 5.17.1.5; FHP-ACA Contract § 5.17.1.5]

f. Company's obligation to establish and maintain an HFS-approved peer-review program to review the quality of care that Provider/Subcontractor provides to Enrollees. [ICP Contract § 5.19.5; FHP-ACA Contract § 5.19.5]

g. Company's obligation to provide orientation, education, and training for Provider/Subcontractor as set forth in the State Contracts, including without limitation (i) training on how to identify, recognize potential concerns related to, and report on suspected or alleged abuse, neglect, and exploitation being suffered by Enrollees, and (ii) education on the application of required clinical guidelines. [ICP Contract §§ 5.9, 5.20.1, 5.20.2, Attachment XI ¶ 9, Attachment XXI ¶ 3; FHP-ACA Contract §§ 5.9, 5.20.4, 5.20.5, Attachment XI ¶ 9, Attachment XXI ¶ 3]

h. Company's obligation to participate in any State-required performance-improvement projects. [ICP Contract § 7.16.5; FHP-ACA Contract § 7.16.5]

i. Company's obligation to remit to Provider/Subcontractor, if applicable, any "hospital access payments" authorized under 305 ILCS 5/5A-12.2(s)–(t) and 305 ILCS 5/5A-12.5 (Public Act 98-651, enacted June 14, 2014). [ICP Contract § 7.1 5; FHP-ACA Contract § 7.1.2]

j. Company's obligation to respond to any letter of concern, written deficiency notice, or request for a corrective action plan that Company receives from the State relating to Provider/Subcontractor or the services that are within the scope of the Agreement. [ICP Contract § 7.16.6.1; FHP-ACA Contract § 7.16.6.1]

k. Company's obligations and responsibilities relating to the "HMO self-evaluation structure" and associated activities set forth in 77 Ill. Admin. Code § 240.60. [77 Ill. Admin. Code § 240.50(d)(1)(C)]

14. Notice of Legal Action. If Provider/Subcontractor, its parent, or one of its affiliates becomes a party to any litigation, investigation, or transaction that may reasonably be considered to have a material impact on Provider/Subcontractor's ability to perform under the Agreement, Provider/Subcontractor shall immediately notify Company in writing. [ICP Contract § 9.1.24, FHP-ACA Contract § 9.1.24]

15. State Review of Agreement. Provider/Subcontractor acknowledges and agrees that Company may be required to submit a copy of the Agreement to HFS for review, and that HFS reserves the right to require Company to amend the Agreement as reasonably necessary to conform to Company's duties and obligations under the State Contracts. [ICP Contract § 5.28.10; FHP-ACA Contract § 5.28.10]

16. **Termination of Agreement and Effect Thereof.**

a. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the parties. Furthermore, in the event this Illinois Medicaid Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or Product Participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties.

b. Notwithstanding anything in the Agreement to the contrary, if either Company or Provider/Subcontractor seeks (i) to terminate the Agreement "with cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least sixty (60) days' written notice to the other party; or (ii) to terminate the Agreement "without cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least ninety (90) days' written notice to the other party. Furthermore, Provider/Subcontractor shall cooperate with Company with respect to Company's obligation to provide timely notice to Enrollees of any termination that would curtail or eliminate services to such Enrollees, with such notice to be sent (i) at least sixty (60) days prior to that termination, or (ii) immediately, if Company receives less than sixty (60) days' notice of that termination from Provider/Subcontractor. The notice to be sent to Enrollees shall include instructions regarding referrals that have previously been issued and appointments that may be pending. [50 Ill. Admin. Code § 5241.50(a)(5)–(6); 305 ILCS 5/5F-40(a)]

c. Notwithstanding anything in the Agreement to the contrary, Company shall retain the right to terminate the Agreement, or impose other sanctions, if the performance of Provider/Subcontractor is inadequate. Company shall monitor the performance of Provider/Subcontractor on an ongoing basis, shall subject Provider/Subcontractor to formal review on no less than a triennial basis, and to the extent deficiencies or areas for improvement are identified during an informal or formal review, shall require Provider/Subcontractor to take appropriate corrective action. Furthermore, Company shall promptly terminate the Agreement if Provider/Subcontractor is or becomes terminated, barred, or suspended, or has voluntarily withdrawn as a result of a settlement agreement, under either Section 1128 or Section 1128A of the Social Security Act, from participating in any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act or are otherwise excluded from participation in the HFS Medical Program. [ICP Contract §§ 5.28.7, 5.28.9; FHP-ACA Contract §§ 5.28.7, 5.28.9]

17. **Maintenance, Access to, and Confidentiality of Records.**

a. Provider/Subcontractor shall maintain books and records relating to the performance of the State Contracts and the Agreement and necessary to support amounts charged under the State Contracts and the Agreement. Books and records, including information stored in databases or other computer systems, shall be maintained by Provider/Subcontractor for a period of three (3) years from the later of the date of final payment under the Agreement or completion of the Agreement, or such longer time as may be required by federal law or regulation. Books and records required to be maintained under this provision shall be available for review or audit by representatives of any Authorized Persons (along with the Executive Inspector General and the Chief Procurement Officer) upon reasonable notice and during normal business hours. Provider/Subcontractor shall cooperate fully with any such audit and with any investigation conducted by any of these entities. Failure to maintain the books and records required by this provision shall establish a presumption in favor of the State for the recovery of any funds paid by the State under the State Contracts for which adequate books and records are not available to support the purported disbursement. Provider/Subcontractor shall not impose a charge for audit or examination of Provider/Subcontractor's books and records. [ICP Contract § 9.1.2; FHP-ACA Contract § 9.1.2]

b. Provider/Subcontractor may have or gain access to confidential data or information owned or maintained by the State or Company in the course of carrying out Provider/Subcontractor's responsibilities under the Agreement and/or the State Contracts. Provider/Subcontractor shall presume all information received from the State or Company, or to which it gains access pursuant to the Agreement and/or the State Contracts, is confidential. No confidential data collected, maintained, or used in the course of performance of the Agreement and/or the State Contracts shall be disseminated except as authorized by law and with the written consent of the State and/or Company, as applicable, either during the term of the State Contracts or thereafter, unless otherwise expressly provided in the State Contracts. Provider/Subcontractor must return any and all data collected, maintained, created, or used in the course of the performance of the Agreement and/or the State Contracts, in whatever form it is maintained, promptly at the earlier of the termination of the Agreement or the termination of the State Contracts, or earlier at the request of the State, or notify the State and/or Company, as applicable, in writing of its destruction. The foregoing obligations shall not apply to confidential data or information that is: (i) lawfully in Provider/Subcontractor's possession prior to its acquisition from the State and/or Company; (ii) received in good faith from a third-party not subject to any confidentiality obligation to the State and/or Company; (iii) now is or later becomes publicly known through no breach of confidentiality obligation by Provider/Subcontractor; or (iv) is independently developed by Provider/Subcontractor without the use or benefit of the confidential information of the State and/or Company. [ICP Contract § 9.1.6; FHP-ACA Contract § 9.1.6]

c. Provider/Subcontractor shall ensure that all information, records, data, and data elements pertaining to applicants for and recipients of public assistance, or to providers, facilities, and associations, shall be protected from unauthorized disclosure by Provider/Subcontractor and Provider/Subcontractor's employees, by Provider/Subcontractor's corporate affiliates and their employees, and by Provider/Subcontractor's subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 U.S.C. § 654(26); 42 C.F.R. Part 431, Subpart F; and 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subparts A and E. To the extent that Provider/Subcontractor, in the course of performing under the terms of the Agreement, serves as a business associate of Company and/or HFS, as "business associate" is defined in the HIPAA Privacy Rule (45 C.F.R. § 160.103), Provider/Subcontractor shall assist Company and/or HFS in responding to the client as provided in the HIPAA Privacy Rule, and shall maintain for a period of six (6) years any records relevant to an individual's eligibility for services under the HFS Medical Program. [ICP Contract § 9.1.21; FHP-ACA Contract § 9.1.21]

d. Provider/Subcontractor, to which Company provides Enrollee PHI that Company has received from HFS or created or received by Company on behalf of HFS, agrees to the same restrictions and conditions that apply under the terms of the State Contracts to Company with respect to such information. [ICP Contract, Attachment VI § C.5; FHP-ACA Contract, Attachment VI § C.5]

18. **Medical Records. With respect to Enrollee medical records:**

a. In addition to the requirements set forth in the Agreement, Provider/Subcontractor shall maintain Enrollee medical records in a timely, legible, accurate, current, complete, and organized manner, with appropriate dates and identification and initialing/signature of the Provider/Subcontractor, to facilitate retrieval

and compilation of records, to ensure Enrollee continuity of care, and to permit effective and confidential patient care and quality review. For each encounter or episode of care that Provider/Subcontractor has with an Enrollee, Provider/Subcontractor shall place the following information into the Enrollee's medical records: (1) the reason for the encounter; (2) evidence of the Provider/Subcontractor's assessment of the Enrollee's health problems; (3) current diagnosis of the Enrollee, including the results of any diagnostic tests; (4) the plan of treatment, including any therapies and health education; (5) any medical history relevant to the current episode of care; and (6) confirmation that all outcomes of ancillary reports, such as laboratory tests and x-rays, have been reviewed by the individual or entity who ordered the reports and that follow-up actions have been taken regarding report results that are deemed significant by the individual or entity who ordered those reports. [77 Ill. Admin. Code §§ 240.50(c)(1), 240.90(a)–(b); ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

b. Provider/Subcontractor shall ensure that Enrollee medical records contain documented efforts to obtain Enrollee consent when required by law. Provider/Subcontractor shall furthermore only release Enrollee medical records to Authorized Persons, or to any primary care provider (PCP), women's health care provider (WHCP), or other Provider of Enrollee (subject to Enrollee's consent when required by law), and shall only release original Enrollee medical records in accordance with federal or State law, court orders, subpoenas, or a valid records-release form executed by the Enrollee. Provider/Subcontractor shall protect the confidentiality and privacy of minors, and shall abide by all federal and State laws regarding the confidentiality and disclosure of medical records, mental health records, and any other information about Enrollees. Provider/Subcontractor shall produce Enrollee medical records to HFS upon request. [ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

c. If Provider/Subcontractor is an Enrollee's primary care provider (PCP), Provider/Subcontractor shall furthermore maintain a permanent medical record for that Enrollee to ensure continuity of care. The medical record for each Enrollee who has had a routine, scheduled appointment with his/her primary care provider (PCP) shall include the following information: (1) identification; (2) patient history; (3) known past surgical procedures; (4) known past and current diagnoses and problems; and (5) known allergies and untoward reactions to drugs. [77 Ill. Admin. Code § 240.90(c); ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

d. If Enrollee changes PCPs or "medical homes," Provider/Subcontractor shall forward Enrollee's medical records or copies thereof to the new PCP or "medical home" promptly upon Enrollee's transfer. [ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

e. Provider/Subcontractor shall only record diagnosis codes in Enrollee's medical records at the time of creation of that medical record, and shall not retroactively adjust any such diagnosis codes except to correct errors. [ICP Contract § 7.4.1; FHP-ACA Contract § 7.4.1]

19. Use of Hospitalists. Neither Company nor Provider/Subcontractor shall require or otherwise mandate, whether by contract, written policy, or procedure, any Enrollee to substitute his or her participating primary care provider (PCP) during inpatient hospitalization, such as with a hospitalist physician, without the agreement of that Enrollee's participating primary care provider (PCP). Company and Provider/Subcontractor (if applicable) shall inform Enrollees of any policies, recommendations, or guidelines concerning the substitution of the Enrollee's primary care provider (PCP) when hospitalization is necessary in the manner set forth in 215 ILCS 5/15(d)–(e). [215 ILCS 134/30(c)]

20. **Provider Enrollment, Credentialing, Licensure, and Privileges.**

a. Provider/Subcontractor shall be enrolled as a provider in the HFS Medical Program (as defined below), if such enrollment is required by HFS's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. Provider/Subcontractor shall not, in turn, contract or subcontract with an individual or entity that has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement. For purposes of this provision, the term "HFS Medical Program" means the (i) Illinois Medical Assistance Program administered under Article V of the Illinois Public Aid Code (305 ILCS 5/5-1 *et seq.*) or its successor program, and Titles XIX (42 U.S.C. § 1396 *et seq.*) and XXI (42 U.S.C. § 1397aa *et seq.*) of the Social Security Act, and Section 12-4.35 of the Illinois Public Aid Code (305 ILCS 5/12-4.35); and (ii) the State Children's Health Insurance Program administered under 215 ILCS 106 and Title XXI of the Social Security Act (42 U.S.C. § 1397aa *et seq.*). [ICP Contract §§ 1.71, 5.28.4; FHP-ACA Contract §§ 1.75, 5.28.4]

b. Provider shall comply with all credentialing and recredentialing policies and procedures that Company implements to verify Provider's credentials, including without limitation by completing a credentialing application in accordance with applicable policies and procedures. Furthermore, Provider shall comply with all applicable credentialing/recredentialing standards and requirements set forth in the State Contracts and in applicable federal and State laws, regulations, and written policies. [ICP Contract § 5.7.1, Attachment XI ¶ 8; FHP-ACA Contract § 5.8.1, Attachment XI ¶ 8]

c. If Provider/Subcontractor operates a laboratory testing site that provides services to Enrollees, (i) that site shall possess a valid Clinical Laboratory Improvement Amendment (CLIA) certificate and comply with the CLIA regulations found at 42 C.F.R. Part 493, and (ii) Provider/Subcontractor shall report lab values to Company directly. [ICP Contract §§ 5.19.2, 5.28.9.4; FHP-ACA Contract §§ 5.19.2, 5.28.9.4]

d. If Provider is a physician, such physician Provider shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is also a participating Provider with Company; or, in lieu of these admitting and/or delivery privileges, such physician Provider shall have a written referral agreement with a separate physician who is a participating Provider with Company and who has such privileges at a hospital that is also a participating Provider with Company. Such physician Provider shall coordinate care with the referring physician and shall ensure that Enrollee medical records are appropriately transferred; the physicians' written referral agreement shall contain appropriate provisions that document and require such coordination of care and transfer of medical records. [ICP Contract § 5.28.1.2; FHP-ACA Contract § 5.28.1.2]

e. If Provider/Subcontractor provides long-term care and HCBS services under the Agreement, Provider/Subcontractor shall be approved and authorized by the State to provide such Covered Services, and shall only provide to Enrollees those particular Covered Services for which they are approved and authorized. [FHP-ACA Contract § 5.8.5]

21. **Disclosure of Ownership and Control; Prohibited Relationships; Background Checks.**

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in federal health care programs, or is 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, Provider/Subcontractor shall disclose to Company: any required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest information; and information on any criminal convictions regarding Provider/Subcontractor and any owner(s) and managing employee(s) at the time the Agreement is executed and annually thereafter, and any time there are changes to such information. [ICP Contract § 9.2.34; FHP-ACA Contract § 9.2.34]

b. No Provider/Subcontractor, no individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider/Subcontractor, and no officer, director, agent, or managing employee (*i.e.*, general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over that Provider/Subcontractor or who directly or indirectly conducts the day-to-day operation of that Provider/Subcontractor) shall be an entity or individual: (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)–(3) of the Social Security Act (42 U.S.C. § 1320a-7(b)(1)-(3)); (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a, 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a State health care program. [ICP Contract § 9.2.34; FHP-ACA Contract § 9.2.34]

c. Provider/Subcontractor shall not be an Excluded Person (as that term is defined below), and shall not employ, subcontract with, or affiliate with an Excluded Person. The term "Excluded Person" means any individual or entity that (i) under Section 1128 of the Social Security Act, is or has been terminated, barred,

suspended, or otherwise excluded from participation in, or as the result of a settlement agreement has voluntarily withdrawn from participation in, any program under federal law, including any program under Titles IV, XVIII, XIX, XX or XXI of the Social Security Act; (ii) has not been reinstated in the program after a period of exclusion, suspension, debarment, or ineligibility; or (iii) has been convicted of a criminal offense related to the provision of items or services to a federal, state, or local government entity within the last ten (10) years. Provider/Subcontractor acknowledges and agrees that under the State Contracts, Company must terminate its relationship with Provider/Subcontractor immediately upon learning that such Provider/Subcontractor meets the definition of an Excluded Person, and must notify the HFS OIG of the termination. [ICP Contract §§ 5.22, 9.1.32; FHP-ACA Contract §§ 5.22, 9.1.32]

d. Provider/Subcontractor acknowledges and agrees that prior to entering into the Agreement, Company may be required to submit a disclosure statement to HFS identifying any agreements, Providers, and/or Subcontractors in which any of the following have a financial interest of five percent (5%) or more: (a) any individual or entity also having a financial interest of five percent (5%) or more in Company or Company's affiliates as defined by 42 C.F.R. § 455.101; (b) any director, officer, trustee, partner, or employee of Company or Company's Affiliates; and (c) any member of the immediate family of any individual or entity designated above. [ICP Contract § 5.28.12; FHP-ACA Contract § 5.28.12]

e. Provider/Subcontractor acknowledges and agrees that the State may conduct, at the State's expense and whenever the State deems it reasonably necessary for security reasons, criminal and driver history background checks of Provider/Subcontractor and its officers, employees, or agents, and furthermore acknowledges and agrees that Provider/Subcontractor shall immediately reassign any such individual who, in the opinion of the State, does not pass the background checks. [ICP Contract § 9.1.13; FHP-ACA Contract § 9.1.13]

22. Fraud, Abuse and Misconduct. Provider/Subcontractor shall report immediately in writing to Company and to the HFS OIG any suspected fraud, abuse, or misconduct associated with any service or function provided for under the Agreement and/or the State Contracts by any parties directly or indirectly affiliated with the Agreement and/or the State Contracts, including without limitation Company and Company's staff, Provider/Subcontractor and its employees and subcontractors, and HFS employees or contractors. Provider/Subcontractor shall make this report to Company and to the HFS OIG within three (3) days after first suspecting fraud, abuse, or misconduct. Provider/Subcontractor shall not conduct any investigation of the suspected fraud, abuse, or misconduct without the express concurrence of the HFS OIG; the foregoing notwithstanding, Provider/Subcontractor may conduct and continue investigations necessary to determine whether reporting is required under this provision. Provider/Subcontractor must report the results of such an investigation to the HFS OIG as described above. Provider/Subcontractor shall cooperate with all investigations of suspected fraud, abuse, or misconduct reported pursuant to this provision. Nothing in this provision precludes Company or Provider/Subcontractor from establishing measures to maintain quality of services and control costs that are consistent with their usual business practices, from conducting themselves in accordance with their respective legal or contractual obligations, or from taking internal personnel-related actions. [ICP Contract §§ 5.31.1, 9.1.29; FHP-ACA Contract §§ 5.31.1, 9.1.29]

23. Offshore Services. Provider/Subcontractor is prohibited from using any individual or entity (an "Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative, or other individual or entity) to perform any services in connection with the State Contracts 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/Subcontractor further agrees that Company has the right to audit any Offshore Entity prior to the provision of any Offshore Services. Provider/Subcontractor further represents and warrants that it does not and will not permit any Enrollees' protected health information (PHI) or other personal information to be accessible by any Offshore Entity, without prior written notice to Company and Company's prior written approval of such Offshore Entity. In the event that Company agrees in advance and in writing to permit Provider/Subcontractor to use an Offshore Entity to perform any services in connection with the State Contracts and Company agrees that such Offshore Entity will receive, process, transfer, handle, store, or access Enrollee PHI as defined at 45 C.F.R. § 160.103, Provider/Subcontractor agrees that Offshore Services that involve Enrollee PHI are subject to CMS reporting within thirty (30) days of: (a) performing, or contracting with an Offshore Entity to perform, Offshore Services, and (b) any time Provider/Subcontractor changes the Offshore Services that an Offshore Entity will perform.

24. Business Enterprise Program (BEP) Registration. In the event that Provider/Subcontractor is a minority-owned business, a female-owned business, or a business owned by persons with disabilities, then Provider/Subcontractor shall seek and obtain State certification as a Business Enterprise Program (BEP) vendor under the Business Enterprise Program Act for Minorities, Females and Persons with Disabilities. Provider/Subcontractor shall furthermore cooperate with Company with respect to Company's obligations under the State Contract related to the Business Enterprise Program (BEP) and shall, among other things, maintain a record of all relevant data with respect to the utilization of BEP-certified individuals and entities, including, but not limited to, payroll records, invoices, canceled checks, and books of account, for a period of at least five (5) years after the completion of the Agreement. [ICP Contract §§ 2.92, 7.16.2; FHP-ACA Contract §§ 2.92, 7.16.2]

25. Marketing Activities. Provider/Subcontractor shall not engage in any inappropriate or unallowable marketing activities and practices as set forth in the State Contracts and 42 C.F.R. § 438.104, and shall submit to Company for its review any marketing or information materials of Provider/Subcontractor that relate to the State Contracts, prior to disseminating same. Provider/Subcontractor furthermore shall not induce any employees of the State to improperly reveal any confidential information regarding Enrollees or otherwise use such confidential information in a fraudulent manner. [ICP Contract § 4.16.3; FHP-ACA Contract § 4.16.3]

26. Compliance with Laws, the State Contracts, and Company Policies and Procedures.

a. Provider/Subcontractor shall perform all services and other duties under the Agreement in accordance and compliance with, and subject to, all applicable federal, State, and local laws, rules, ordinances, regulations, orders, federal circulars, and license and permit requirements in the performance of the Agreement, including without limitation, the Managed Care Reform and Patient Rights Act (215 ILCS 134/ 1 *et seq.*), the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by the Illinois Department of Financial and Professional Regulation, the Illinois Department of Public Health, and/or federal CMS. Company shall be in compliance with applicable tax requirements and shall be current in payment of such taxes. Company shall obtain at its own expense all licenses and permissions necessary for the performance of the Agreement. [ICP Contract §§ 2.2, 2.5, 9.1.12; FHP-ACA Contract §§ 2.2, 2.5, 9.1.12]

b. Provider/Subcontractor shall be bound by the terms and conditions of the State Contracts that are appropriate to the services provided by, or activities delegated to, Provider/Subcontractor in connection with the State Contracts. These terms and conditions include, without limitation, the record-keeping and audit provisions of the State Contracts, such that the Authorized Persons shall have the same rights to audit and inspect Provider/Subcontractor (and any downstream providers or subcontractors thereof) as they have to audit and inspect Company. [ICP Contract § 5.28.1.1; FHP-ACA Contract § 5.28.1.1]

c. Provider/Subcontractor shall comply with the prior-authorization requirements and processes set forth in Company's policies and procedures. [ICP Contract §§ 5.16.5, 5.16.6; FHP-ACA Contract § 5.16.5, 5.16.6]

d. Provider/Subcontractor shall comply with all utilization-management and peer-review programs, processes, and timeframes established by Company. [ICP Contract, Attachment XII ¶ 4; FHP-ACA Contract, Attachment XII ¶ 4]

27. State Employee Handbook. If Provider/Subcontractor or any of its employees and subcontractors provide services under the Agreement at a location controlled by HFS or any other State agency, Provider/Subcontractor shall abide by all applicable provisions of the controlling State agency's Employee Handbook. [ICP Contract § 9.1.27; FHP-ACA Contract § 9.1.27]

28. Prohibition on Gifts. Provider/Subcontractor and its principals, employees, and subcontractors are prohibited from giving gifts to HFS employees, and from giving gifts to, or accepting gifts from, any individual or entity

that has a contemporaneous contract with HFS involving duties or obligations related to the Agreement and/or the State Contracts. [ICP Contract § 9.1.30; FHP-ACA Contract § 9.1.30]

29. No Transfer of Liability to Providers. Neither Company nor Subcontractor shall transfer or attempt to transfer to any health care provider, by indemnification, hold harmless, or contribution requirements that are set forth in any contract, written policy, or procedure, any liability relating to activities, actions, or omissions of Company and/or Subcontractor or their respective officers, employees, or agents; provided, however that nothing in this provision shall relieve any health care provider from liability for his, her, or its own negligence in the performance of his, her, or its duties arising from treatment of an Enrollee. [215 ILCS 134/95]

30. Capitated Contracts. If Company compensates Provider/Subcontractor under the Agreement on a capitated basis for furnishing, arranging, or providing health care services:

a. Provider/Subcontractor agrees that in no event, including but not limited to nonpayment by Company of amounts due to Provider/Subcontractor under the Agreement, insolvency of Company, or any breach of the Agreement by Company, shall Provider/Subcontractor or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Enrollee or persons acting on the Enrollee's behalf (other than Company) for services provided pursuant to the Agreement, except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Enrollees and persons acting on the Enrollees' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider/Subcontractor and the Enrollee or persons acting on the Enrollee's behalf (other than Company). [50 Ill. Admin. Code § 5241.50(e)]

b. Provider/Subcontractor shall submit timely encounter data/records for all Covered Services that it has provided to Enrollees, in the format specified by the State, so that Company can meet the encounter-reporting specifications and requirements set forth in the State Contracts. Provider/Subcontractor shall be responsible for transmitting all data to Company as required by 42 C.F.R. § 438. [ICP Contract § 7.11.3; FHP-ACA Contract §§ 5.6.6, 7.11.3]

c. If Provider/Subcontractor is a "Managed Care Organization" as that term is defined in 50 Ill. Admin. Code § 5241.20, Provider/Subcontractor shall submit to Company copies of Provider/Subcontractor's quarterly financial statements, which shall include Provider/Subcontractor's balance sheet and statements of income and cash flow within forty-five (45) days after the end of each fiscal period. In addition, Provider/Subcontractor shall submit, within ninety (90) days after the end of Provider/Subcontractor's fiscal year, copies of Provider/Subcontractor's audited annual financial statements prepared in accordance with generally accepted accounting principles, if available. Provider/Subcontractor acknowledges and agrees that HFS, at its discretion, may require Company to submit for HFS's inspection the financial statements that Company has received from Provider/Subcontractor (which such financial statements shall be deemed confidential by HFS). Provider/Subcontractor agrees to fully cooperate with, and disclose all relevant information requested by, Company's actuaries for the preparation of such actuaries' opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16. Company acknowledges that in the event of Provider/Subcontractor's insolvency, Company is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Company's Enrollees. [50 Ill. Admin Code §5241.50(d)] For purposes of this provision, "Managed Care Organization" or "MCO" means a partnership, association, corporation, or other legal entity, including but not limited to individual practice associations (IPAs) and physician hospital organizations (PHOs), that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services. [50 Ill. Admin. Code § 5241.20]

31. Required Certifications of Provider/Subcontractor. Provider/Subcontractor acknowledges and agrees that its compliance with Section 9.2 of each of the State Contracts and each subsection of Section 9.2 (collectively, the "Standard Certifications") is a material requirement and condition of this Agreement during the entire term thereof,

including during any renewal periods. By executing the Agreement, Provider/Subcontractor certifies compliance with the Standard Certifications in their entirety, and Provider/Subcontractor is under a continuing obligation to remain in compliance with, and to report any non-compliance with respect to, the Standard Certifications. Furthermore, Provider/Subcontractor shall include the Standard Certifications in any subcontracts or other contracts with its downstream entities or related entities that Provider/Subcontractor enters into in connection with the State Contracts. During the term of the State Contracts, Provider/Subcontractor shall confirm compliance with the Standard Certifications in the manner and format determined by the State by the date specified by the State, and in no event later than July 1 of each year that the State Contracts remains in effect. As part of each Standard Certification, Provider/Subcontractor acknowledges and agrees that if Provider/Subcontractor or its subcontractors, downstream entities, or related entities provide false information, or fail to be or remain in compliance with the Standard Certifications, one or more of the following sanctions will apply: (a) the Agreement may be void by operation of law; (b) the State may void the Agreement; and (c) Provider/Subcontractor and its subcontractors, downstream entities, or related entities may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty. [ICP Contract § 9.2.1; FHP-ACA Contract § 9.2.1]

The Standard Certifications are set forth below:

a. Provider/Subcontractor certifies it and its employees will comply with applicable provisions of the United States Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101, *et seq.*), and applicable rules in the performance of this Agreement. [ICP Contract § 9.2.2; FHP-ACA Contract § 9.2.2]

b. Provider/Subcontractor certifies, if applicable, that it is not in default on an educational loan (5 ILCS 385/3). This applies to individuals, sole proprietorships, partnerships, and individuals as members of LLCs. [ICP Contract § 9.2.3; FHP-ACA Contract § 9.2.3]

c. Provider/Subcontractor (if an individual, sole proprietor, partner, or an individual as member of an LLC) certifies, if applicable, that it has not received (i) an early retirement incentive prior to 1993 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133.3, or (ii) an early retirement incentive on or after 2002 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133 (30 ILCS 105/15a). [ICP Contract § 9.2.4; FHP-ACA Contract § 9.2.4]

d. Provider/Subcontractor certifies, if applicable, that it is a properly formed and existing legal entity (30 ILCS 500/1.15.80, 20-43), and as applicable has obtained an assumed name certificate from the appropriate authority, or has registered to conduct business in Illinois and is in good standing with the Illinois Secretary of State. [ICP Contract § 9.2.5; FHP-ACA Contract § 9.2.5]

e. Provider/Subcontractor certifies that it has neither been convicted of bribing or attempting to bribe an officer or employee of the State or any other state, nor made an admission of guilt of such conduct that is a matter of record (30 ILCS 500/50-5). [ICP Contract § 9.2.7; FHP-ACA Contract § 9.2.7]

f. If Provider/Subcontractor has been convicted of a felony, Provider/Subcontractor certifies at least five (5) years have passed after the date of completion of the sentence for such felony, unless no person held responsible by a prosecutor's office for the facts upon which the conviction was based continues to have any involvement with the business (30 ILCS 500/50-10). [ICP Contract § 9.2.8; FHP-ACA Contract § 9.2.8]

g. If Provider/Subcontractor, or any officer, director, partner, or other managerial agent of Provider/Subcontractor, has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law of 1953, Provider/Subcontractor certifies that at least five (5) years have passed since the date of the conviction. Provider/Subcontractor further certifies that it is not barred

from being awarded a contract and acknowledges that the State shall declare the Agreement void if this certification is false (30 ILCS 500/50-10.5). [ICP Contract § 9.2.9; FHP-ACA Contract § 9.2.9]

h. Provider/Subcontractor certifies that it is not barred from having a contract with the State based on violating the prohibition on providing assistance to the State in identifying a need for a contract (except as part of a public request for information process) or by reviewing, drafting, or preparing a solicitation or similar documents for the State (30 ILCS 500/50-10.5e). [ICP Contract § 9.2.10; FHP-ACA Contract § 9.2.10]

i. Provider/Subcontractor certifies that it and its affiliates are not delinquent in the payment of any debt to the State (or if delinquent has entered into a deferred payment plan to pay the debt), and Provider/Subcontractor and its affiliates acknowledge that the State may declare the Agreement void if this certification is false (30 ILCS 500/50-11) or if Provider/Subcontractor or an affiliate later becomes delinquent and has not entered into a deferred payment plan to pay off the debt (30 ILCS 500/50-60). [ICP Contract § 9.2.11; FHP-ACA Contract § 9.2.11]

j. Provider/Subcontractor certifies that it and its affiliates shall collect and remit Illinois Use Tax on all sales of tangible personal property into the State in accordance with provisions of the Illinois Use Tax Act (30 ILCS 500/50-12) and acknowledges that failure to comply can result in the Agreement being declared void. [ICP Contract § 9.2.12; FHP-ACA Contract § 9.2.12]

k. Provider/Subcontractor certifies that it has not been found by a court or the Pollution Control Board to have committed a willful or knowing violation of the Environmental Protection Act within the last five (5) years, and is therefore not barred from being awarded a contract (30 ILCS 500/50-14). [ICP Contract § 9.2.13; FHP-ACA Contract § 9.2.13]

l. Provider/Subcontractor certifies that it has not paid any money or valuable thing to induce any person to refrain from bidding on a State contract, nor has Provider/Subcontractor accepted any money or other valuable thing, or acted upon the promise of same, for not bidding on a State contract (30 ILCS 500/50-25). [ICP Contract § 9.2.14; FHP-ACA Contract § 9.2.14]

m. Provider/Subcontractor certifies that it is not in violation of the "Revolving Door" section of the Illinois Procurement Code (30 ILCS 500/50-30). [ICP Contract § 9.2.15; FHP-ACA Contract § 9.2.15]

n. Provider/Subcontractor certifies that it has not retained a person to attempt to influence the outcome of a procurement decision for compensation contingent in whole or in part upon the decision or procurement (30 ILCS 500/50-38). [ICP Contract § 9.2.16; FHP-ACA Contract § 9.2.16]

o. Provider/Subcontractor certifies that it will report to the Illinois Attorney General and the Chief Procurement Officer any suspected collusion or other anti-competitive practice among any bidders, offerors, contractors, proposers, or employees of the State (30 ILCS 500/50-40, 50-45, 50-50). [ICP Contract § 9.2.17; FHP-ACA Contract § 9.2.17]

p. In accordance with the Steel Products Procurement Act, Provider/Subcontractor certifies that steel products used or supplied in the performance of a contract for public works shall be manufactured or produced in the United States, unless the executive head of the procuring agency grants an exception (30 ILCS 565). [ICP Contract § 9.2.18; FHP-ACA Contract § 9.2.18]

q. If Provider/Subcontractor employs twenty-five (25) or more employees, Provider/Subcontractor certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580). [ICP Contract § 9.2.19; FHP-ACA Contract § 9.2.19]

r. Provider/Subcontractor certifies that neither Provider/Subcontractor nor any substantially owned affiliate of Provider/Subcontractor is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce (30 ILCS 582). [ICP Contract § 9.2.20; FHP-ACA Contract § 9.2.20]

s. Provider/Subcontractor certifies that it has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33E-3, E-4). [ICP Contract § 9.2.21; FHP-ACA Contract § 9.2.21]

t. Provider/Subcontractor certifies that it complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105). [ICP Contract § 9.2.22; FHP-ACA Contract § 9.2.22]

u. Provider/Subcontractor certifies that it does not pay dues to or reimburse or subsidize payments by its employees for any dues or fees to any "discriminatory club" (775 ILCS 25/2). [ICP Contract § 9.2.23; FHP-ACA Contract § 9.2.23]

v. Provider/Subcontractor certifies that it complies with the State Prohibition of Goods from Forced Labor Act, and certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Agreement have been or will be produced in whole or in part by forced labor, or indentured labor under penal sanction (30 ILCS 583). [ICP Contract § 9.2.24; FHP-ACA Contract § 9.2.24]

w. Provider/Subcontractor certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Agreement have been produced in whole or in part by the labor or any child under the age of twelve (30 ILCS 584). [ICP Contract § 9.2.25; FHP-ACA Contract § 9.2.25]

x. Provider/Subcontractor certifies that it is not in violation of Section 50-14.5 of the Illinois Procurement Code (30 ILCS 500/50-14.5), which states: "Owners of residential buildings who have committed a willful or knowing violation of the Lead Poisoning Prevention Act (410 ILCS 45) are prohibited from doing business with the State until the violation is mitigated." [ICP Contract § 9.2.26; FHP-ACA Contract § 9.2.26]

y. Provider/Subcontractor warrants and certifies that it and, to the best of its knowledge, its subcontractors, downstream entities, or related entities, have and will comply with Executive Order No. 1 (2007). That Order generally prohibits contractors and subcontractors from hiring the then-serving Illinois Governor's family members to lobby procurement activities of the State, or any other unit of government in the State including local governments if that procurement may result in a contract valued at over $25,000. This prohibition also applies to hiring for that same purpose any former State employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity. [ICP Contract § 9.2.27; FHP-ACA Contract § 9.2.27]

z. Provider/Subcontractor certifies that information technology, including electronic information, software, systems, and equipment developed or provided under the Agreement will comply with the applicable

requirements of the Illinois Information Technology Accessibility Act Standards as published at www.dhs.state.il.us/iitaa (30 ILCS 587). [ICP Contract § 9.2.28, FHP-ACA Contract § 9.2.28]

aa. Provider/Subcontractor certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal or State department or agency, and is not currently barred or suspended from contracting with the State under Section 50-35(f), 50-35(g) or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 *et seq.* If at any time during the term of the Agreement, Provider/Subcontractor becomes barred, suspended, or excluded from participation in this transaction, Provider/Subcontractor shall, within thirty (30) days after becoming barred, suspended, or excluded, provide to HFS a written description of each offense causing the exclusion, the date(s) of the offense(s), the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence completed. [ICP Contract § 9.2.29; FHP-ACA Contract § 9.2.29]

bb. Provider/Subcontractor certifies that neither Provider/Subcontractor, nor any party directly or indirectly affiliated with Provider/Subcontractor, including but not limited to Provider/Subcontractor's officers, directors, employees, and subcontractors, and the officers, directors, and employees of Provider/Subcontractor's subcontractors, shall have or acquire any Conflict of Interest (as defined below) in performance of the Agreement. Provider/Subcontractor shall disclose in writing any Conflicts of Interest to HFS no later than seven (7) days after learning of the Conflict of Interest. HFS may initiate any inquiry as to the existence of a Conflict of Interest, and Provider/Subcontractor shall cooperate with all such inquiries. HFS shall determine, in its sole discretion, whether a Conflict of Interest exists or whether Provider/Subcontractor failed to make any required disclosure. If HFS concludes that a Conflict of Interest exists, or that Provider/Subcontractor failed to disclose any Conflict of Interest, HFS may impose one or more remedies in its sole discretion, including without limitation the elimination of the Conflict of Interest or the non-renewal or termination of the Agreement. [ICP Contract § 9.2.30; FHP-ACA Contract § 9.2.30]

i. For purposes of this provision, "Conflict of Interest" shall mean an interest of Provider/Subcontractor, or any entity described above, which may be direct or indirect, professional, personal, financial, or beneficial in nature that, in the sole discretion of HFS, compromises, appears to compromise, or gives the appearance of impropriety with regard to Provider/Subcontractor's duties and responsibilities under the Agreement. This term shall include potential Conflicts of Interest. A Conflict of Interest may exist even if no unethical or improper act results from it or may arise where Provider/Subcontractor becomes a party to any litigation, investigation, or transaction that materially impacts Provider/Subcontractor's ability to perform under the Agreement. Any situation where Provider/Subcontractor's role under the Agreement competes with Provider/Subcontractor's professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable individual, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur, or that gives the appearance of the existence of bias or improper conduct, is a Conflict of Interest. [ICP Contract § 9.2.30.1; FHP-ACA Contract § 9.2.30.1]

cc. Provider/Subcontractor certifies that it is in compliance with all applicable standards, orders, or regulations issued pursuant to the federal Clean Air Act (42 U.S.C. § 7401 *et seq.*) and the federal Water Pollution Control Act (33 U.S.C. § 1251 *et seq.*). Violations shall be reported to the United States Department of Health and Human Services and the appropriate Regional Office of the United States Environmental Protection Agency. [ICP Contract § 9.2.31; FHP-ACA Contract § 9.2.31]

dd. Provider/Subcontractor certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of Provider/Subcontractor, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If any funds other than federally appropriated funds have been paid or will be paid to any person for

influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, Provider/Subcontractor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such form is to be obtained at Provider/Subcontractor's request from the HFS Bureau of Fiscal Operations. Provider/Subcontractor shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when the Agreement was executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure. [ICP Contract § 9.2.32; FHP-ACA Contract § 9.2.32]

ee. Provider/Subcontractor certifies that it has read, understands, and is in compliance with the registration requirements of the Elections Code (10 ILCS 5/9-35) and the restrictions on making political contributions and related requirements of the Illinois Procurement Code (30 ILCS 500/20-160 and 50-37). Provider/Subcontractor will not make a political contribution that will violate these requirements, which are effective for the duration of the term of office of the incumbent State governor or for a period of two (2) years after the end of the Agreement's term, whichever is longer. Provider/Subcontractor will certify, as applicable, either that it is not required to register as a business entity with the State Board of Elections, or has registered with the State Board of Elections and will appropriately and timely update that registration. [ICP Contract § 9.2.33 & Attachment X; FHP-ACA Contract § 9.2.33 & Attachment X]

Individual Sites Regulatory Addendum – Exhibit A

Regulatory Compliance Addendum Governing Medicare-Medicaid Dual-Eligible Services

(Aetna Better Health of Illinois)

This Regulatory Compliance Addendum Governing Medicare-Medicaid Dual-Eligible Services (the "Duals Addendum") shall govern the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the *Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services, In Partnership with the State of Illinois Department of Healthcare and Family Services and Aetna Better Health Inc.*, issued on November 1, 2013 (the "Three-Way Contract"), which established and governs the program known as the Illinois Medicare-Medicaid Alignment Initiative a/k/a the MMAI (the "MMAI") and under which Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois ("Company") serves as a managed care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and/or the MMAI.

This Duals Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing the Agreement, as identified on the first page of the Agreement (the "Provider"), and Provider must comply with the requirements set forth herein. Note that this Duals Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement, in the Three-Way Contract, and in the policies, procedures, and provider manual of Company (or its Affiliate, as the case may be). This Duals Addendum and the Agreement may be revised as directed by the State of Illinois and/or by the Centers for Medicare and Medicaid Services.

For purposes of this Duals Addendum, Company may be referred to as "MCO" or "the MCO" (a/k/a managed care organization), and the individuals who are enrolled with Company under the MMAI may be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Duals Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Duals Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Duals Addendum will govern and control with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and/or the MMAI; provided, however, that if there is any conflict between any of the terms of this Agreement, including this Duals Addendum, and the Three-Way Contract, then the terms of the Three-Way Contract will govern and control. Except as provided herein, all other provisions of the Agreement not inconsistent with this Duals Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Duals Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Three-Way Contract and the remainder of the Agreement.

Provider acknowledges and agrees that all provisions of this Duals Addendum shall apply equally to any employees, independent contractors, subcontractors, downstream entities, or related entities of Provider that provide Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, or that provide administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and/or the MMAI, and Provider represents and warrants that Provider shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Duals Addendum and all applicable laws and regulations.

REQUIREMENTS FOR THE MMAI

B. **Illinois State Requirements**

The State of Illinois requires that specific terms and conditions be incorporated into the Agreement. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the following requirements with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract and the MMAI:

1. Hold Harmless of Enrollees. Provider agrees that in no event, including but not limited to the nonpayment by Company of amounts due to Provider under the Agreement, the insolvency of Company, or any breach of the Agreement by Company, shall Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against the Member or persons acting on the Member's behalf (other than Company) for services provided pursuant to the Agreement except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Members and all persons acting on the Members' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf (other than Company). [215 ILCS 125/2-8(a)]

2. Quality Assurance. Provider shall provide, arrange for, or participate in the quality-assurance programs mandated by the Illinois Health Maintenance Organization Act, unless the Illinois Department of Public Health has certified that such programs will be fully implemented without any participation or action from Provider. [215 ILCS 125/2-8(a); 50 Ill Admin. Code § 5241.50(a)(4)]

3. Termination of Agreement. Notwithstanding anything in the Agreement to the contrary, if either Company or Provider seeks (i) to terminate the Agreement "with cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least sixty (60) days' written notice to the other party; or (ii) to terminate the Agreement "without cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least ninety (90) days' written notice to the other party. Furthermore, Provider shall cooperate with Company with respect to Company's obligation to provide timely notice to Enrollees of any termination that would curtail or eliminate services to such Enrollees, with such notice to be sent (i) at least sixty (60) days prior to that termination, or (ii) immediately, if Company receives less than sixty (60) days' notice of that termination from Provider. The notice to be sent to Enrollees shall include instructions regarding referrals that have previously been issued and appointments that may be pending. [50 Ill. Admin. Code § 5241.50(a)(5)-(6); 305 ILCS 5/5F-40(a)]

4. No Discrimination. Provider will not discriminate against Enrollees or potential Enrollees on the basis of payment source. [77 Ill. Admin. Code § 240.50(d)(4)]

5. Anti-Gag Clause; Prohibition on Retaliation. Provider shall not be prohibited or otherwise restricted or discouraged from, and shall not prohibit or otherwise restrict or discourage its downstream providers or subcontractors from, taking any of the following actions so long as those actions are within the lawful scope of the acting party's practice: (a) advocating for medically appropriate health care services for Enrollees, which may include without limitation appealing denials and protesting decisions, policies, and practices; and/or (b) discussing with Enrollees, prospective Enrollees, or the public any health care services, health care providers, utilization review policies, quality assurance policies, or terms and conditions of plans and plan policy. Furthermore, Company shall not retaliate against Provider, and Provider shall not retaliate against its downstream providers or subcontractors, for any of the foregoing actions. Notwithstanding the foregoing, nothing in this provision shall be construed to prohibit: (a) Company or Provider from making a determination not to pay for a particular health care service, from enforcing reasonable peer review or utilization review protocols, or from determining whether a physician or other health care provider has complied with those protocols; and/or (b) a Provider that is a hospital from taking disciplinary actions against a physician as authorized by law. [215 ILCS 134/30(a); 215 ILCS 134/35(a)-(d)]

6. Cooperation with Company. Provider shall cooperate with Company with respect to Company's obligations and responsibilities relating to the "HMO self-evaluation structure" and associated activities set forth in 77 Ill.

Admin. Code § 240.60. [77 Ill. Admin. Code § 240.50(d)(1)(C)]

7. Pharmacy Benefits. Company and Provider shall not permit or allow, whether by contract, written policy, or procedure, any individual or entity to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act (codified at 410 ILCS 620/3.14). [215 ILCS 134/30(b)]

8. Use of Hospitalists. Neither Company nor Provider shall require or otherwise mandate, whether by contract, written policy, or procedure, any Enrollee to substitute his or her participating primary care provider (PCP) during inpatient hospitalization, such as with a hospitalist physician, without the agreement of that Enrollee's participating primary care provider (PCP). Company and Provider (if applicable) shall inform Enrollees of any policies, recommendations, or guidelines concerning the substitution of the Enrollee's primary care provider (PCP) when hospitalization is necessary in the manner set forth in 215 ILCS 5/15(d)-(e). [215 ILCS 134/30(c)]

9. No Transfer of Liability to Downstream Providers. Neither Company nor Provider shall transfer or attempt to transfer to any health care provider, by indemnification, hold harmless, or contribution requirements that are set forth in any contract, written policy, or procedure, any liability relating to activities, actions, or omissions of Company and/or Provider or their respective officers, employees, or agents; provided, however that nothing in this provision shall relieve any health care provider from liability for his, her, or its own negligence in the performance of his, her, or its duties arising from treatment of an Enrollee. [215 ILCS 134/95]

10. Medical Records. With respect to Enrollee medical records:

a. Provider shall maintain Enrollee medical records in a timely, legible, accurate, current, complete, and organized manner, with appropriate dates and identification and initialing/signature of the Provider, to facilitate retrieval and compilation of records and to ensure Enrollee continuity of care. For each encounter or episode of care that Provider has with an Enrollee, Provider shall place the following information into the Enrollee's medical records: (1) the reason for the encounter; (2) evidence of the Provider's assessment of the Enrollee's health problems; (3) current diagnosis of the Enrollee, including the results of any diagnostic tests; (4) the plan of treatment, including any therapies and health education; (5) any medical history relevant to the current episode of care; and (6) confirmation that all outcomes of ancillary reports, such as laboratory tests and x-rays, have been reviewed by the individual or entity who ordered the reports and that follow-up actions have been taken regarding report results that are deemed significant by the individual or entity who ordered those reports. [77 Ill. Admin. Code §§ 240.50(c)(1), 240.90(a)-(b)]

b. If Provider is an Enrollee's primary care provider (PCP), Provider shall furthermore maintain an Enrollee medical record that contains, with respect to each routine, scheduled appointment with that primary care provider (PCP): (1) identification; (2) patient history; (3) known past surgical procedures; (4) known past and current diagnoses and problems; and (5) known allergies and untoward reactions to drugs. [77 Ill. Admin. Code § 240.90(c)]

11. Capitated Contracts. If Company compensates Provider under the Agreement on a capitated basis for furnishing, arranging, or providing health care services:

a. Provider agrees that in no event, including but not limited to nonpayment by Company of amounts due to Provider under the Agreement, insolvency of Company, or any breach of the Agreement by Company, shall Provider or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Member or persons acting on the Member's behalf (other than Company) for services provided pursuant to the Agreement, except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Members and persons acting on the Members' behalf (other than Company) shall be third-party beneficiaries of this provision. This

provision supersedes any oral or written agreement now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf (other than Company). [50 Ill. Admin. Code § 5241.50(e)]

b. If Provider is a "Managed Care Organization" as that term is defined in 50 Ill. Admin. Code § 5241.20, Provider shall submit to Company copies of Provider's quarterly financial statements, which shall include Provider's balance sheet and statements of income and cash flow within forty-five (45) days after the end of each fiscal period. In addition, Provider shall submit, within ninety (90) days after the end of Provider's fiscal year, copies of Provider's audited annual financial statements prepared in accordance with generally accepted accounting principles, if available. Provider acknowledges and agrees that the Illinois Department for Healthcare and Family Services ("HFS"), at its discretion, may require Company to submit for HFS's inspection the financial statements that Company has received from Provider (which such financial statements shall be deemed confidential by HFS). Provider agrees to fully cooperate with, and disclose all relevant information requested by, Company's actuaries for the preparation of such actuaries' opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16. Company acknowledges that in the event of Provider's insolvency, Company is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Company's Enrollees. [50 Ill. Admin Code §5241.50(d)] For purposes of this provision, "Managed Care Organization" or "MCO" means a partnership, association, corporation, or other legal entity, including but not limited to individual practice associations (IPAs) and physician hospital organizations (PHOs), that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services. [50 Ill. Admin. Code § 5241.20]

C. Medicare Requirements

Without limiting any obligation of Provider under the Agreement, Provider shall comply with, and shall cause its Downstream Entities and Related Entities to comply with, the requirements set forth in this Section B with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider), as applicable, that relate to those Covered Services or to the Three-Way Contract and the MMAI (the "Medicare Services") (The terms "Downstream Entities" and "Related Entities" shall have the respective meanings that are ascribed to them in Schedule 1 hereto, and shall include Provider's permanent and temporary employees.) For purposes of this Section B, the Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI shall collectively be referred to as the "Medicare Members," and the managed-care plan that MCO offers under the Three-Way Contract and the MMAI shall be referred to as the "Medicare Plan." Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

12. 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 Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement).

B. MCO shall not pay any amounts beyond the amounts set forth in the applicable Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement), 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 MCO 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, MCO's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. MCO 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 adjust payments to Provider for Covered Services until the earlier of

(i) the discontinuation of the Medicare Payment Adjustment, or (ii) the replacement of the Medicare Payment Adjustment by a subsequent Medicare Payment Adjustment.

C. Pursuant to Section B.5.K. of this Duals Addendum, Provider certifies that the diagnosis codes submitted to MCO for Medicare Members that MCO is required to submit to CMS will be accurate, complete, and truthful (the "Certification"). Provider acknowledges and agrees that MCO may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to MCO 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, "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 (the "Medicare Statute of Limitations"). If MCO makes an overpayment or payment in error to Provider for Medicare Members, MCO 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 MCO's reasonable suspicion of fraud or other intentional misconduct.

E. In no event, including without limitation non-payment by MCO, insolvency of MCO, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Medicare Member or persons (other than MCO) acting on a Medicare Member's behalf for services covered under the Agreement. Provider further agrees that: (i) this provision shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Medicare Members, and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Medicare Member or persons acting on a Medicare Member's behalf. No modification of this provision shall be effective without the prior written approval of the appropriate regulatory entities.

13. ASSIGNMENT. In addition to all other rights of MCO under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Duals Addendum) may be assigned by MCO, at any time and from time to time, in whole or in part, to any other affiliate or successor in interest of MCO. At MCO's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with MCO for those products/lines of business designated by MCO 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, MCO shall provide advance written notice to Provider. In the event of a conflict between this Section and any other provision of the Agreement, the terms of this Section shall supersede and prevail.

14. EFFECT OF TERMINATION. In the event this Duals Addendum is terminated for any reason, such termination shall not constitute termination of any of MCO's other products, plans, or programs.

15. MEDICARE REQUIRED PROVISIONS. Provider agrees to comply with all of the provisions of the Schedules attached hereto and incorporated into this Duals Addendum (including Schedule 1 and any delegated function-specific Schedules that may be appended hereto), and agrees that all terms and conditions in the Agreement applicable to Provider shall also apply to any Downstream Entities of Provider. Provider further acknowledges and agrees that all terms of such Schedules shall apply equally to services provided in connection with the Three-Way Contract and the MMAI, even if such Schedules only refer to Medicare Advantage products. Provider acknowledges that to the extent MCO is delegating to Provider any activities and responsibilities in connection with the Three-Way Contract and the MMAI, MCO may only delegate such activities and responsibilities in a manner consistent with the contractual and legal obligations and duties imposed on MCO under the Three-Way Contract and under applicable Medicare laws, regulations, rules, and other directions of CMS.

16. 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. Compliance; Cooperation. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement will be consistent and comply with MCO's obligations under the Three-Way Contract. Upon request, Provider shall immediately provide to MCO any information that is required by MCO 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 MCO that MCO, 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 MCO 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 MCO for the Medicare Plan from CMS pursuant to the Three-Way Contract, as well as payments that Provider receives from MCO for performing services and functions under the Agreement, constitutes the receipt of federal funds. As a result, Provider, by entering into this Agreement and the terms of this Duals 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 the Three-Way Contract terminates or MCO becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized 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 Duals Addendum, regardless of the reason for termination, including the insolvency of MCO, and shall supersede any oral or written agreement between Provider and a Medicare Member.

E. Policies, Programs & Procedures. Provider agrees to comply with MCO's policies and procedures (which MCO shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Duals Addendum, and the Three-Way Contract and MMAI. Provider agrees to comply with MCO's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies MCO may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that an MCO 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, on behalf of itself and its Downstream Entities (if any), shall preserve records applicable to Medicare Members or to MCO's participation in the Three-Way Contract and MMAI, 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 42 C.F.R. § 423.2480(c) and to maintain all records containing data used by MCO to calculate Medicare medical loss ratios ("MLRs") for MCO's Medicare products and/or evidence needed by MCO 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 MCO to CMS. Provider further agrees that with respect to Medicare Plans, MCO and federal governmental authorities having jurisdiction, and their designees, upon request, shall have access to all MLR Records, and that this right of inspection, evaluation, and audit of MLR Records shall continue for a minimum of ten (10) years from the date such MLRs were reported by MCO to CMS. This provision shall survive the termination of the Agreement, regardless of the cause of termination.

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 (a) all of the contractual and legal obligations and duties imposed on Provider in the Agreement, (b) all provisions required under Medicare laws, regulations, rules, and other directions of CMS (including all of MCO's obligations under such laws, regulations, rules, and other directions related to the scope of Provider's services under the Agreement), and (c) that any delegated services or activities to be performed by subcontractor shall be consistent and comply with the obligations in the Three-Way Contract. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly. Provider acknowledges that, with respect to any services or functions under the Agreement that Provider delegates to a subcontractor, such subcontractor shall be considered a Downstream Entity.

(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 MCO delegates to Provider the selection of providers, MCO retains the right to approve, suspend or terminate such delegation. If MCO delegates the selection of providers, MCO will either review the credentials of medical professionals affiliated with Provider or MCO 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 and/or 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 shall not employ or contract with, with or without compensation, any individual or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in a federal health care program. 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. Furthermore, neither Provider nor any of Provider's Downstream Entities who are and/or will be fully or partially responsible for Provider's performance of its obligations under the Agreement has (i) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; (ii) been excluded from participation in any federal or state funded health program; or (iii) been listed in the Department of Health and Human Services Office of Inspector ("OIG") exclusion list or the General Services Administrative ("GSA") exclusion list. Provider agrees to immediately notify MCO in the event that Provider or any of its Downstream Entities that assist or are involved in Provider's performance of services for Medicare Plans under the Agreement are or become disbarred, excluded, suspended, or otherwise determined to be ineligible to participate in a federal health care program. 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, the "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 the Medicare Plan, 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 Duals Addendum, MCO shall have the right, in its sole discretion and judgment, to terminate this Duals 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 (an "Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative, or other individual or entity) to perform any services for the Medicare Plan 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 MCO, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that MCO has the right to audit any Offshore Entity prior to the provision of Offshore Services for the Medicare Plan. Provider further represents and warrants that it does not and will not permit any Medicare Members' protected health information (PHI) or other personal information to be accessible by any Offshore Entity, without prior written notice to MCO and MCO's prior written approval of such Offshore Entity. In the event that MCO agrees in advance and in writing to permit Provider to use an Offshore Entity to perform any services for Medicare Plans and MCO agrees that such Offshore Entity will receive, process, transfer, handle, store, or access Medicare Member PHI as defined at 45 C.F.R. § 160.103, Provider agrees that Offshore Services that involve Medicare Member 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 MCO 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 MCO and to provide MCO with all such information in such form and manner as requested by MCO. Provider agrees to immediately notify MCO if any encounter data that Provider submitted to MCO for Medicare Members is inaccurate, incomplete, or erroneous, and to cooperate with MCO to correct erroneous encounter data to ensure MCO's compliance with Medicare laws, rules and regulations and CMS instructions.

K. Certification of Data. Provider recognizes that MCO 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 MCO by its contractors and subcontractors. Provider and its subcontractors, if any, hereby certify that any such data submitted to MCO will be accurate, complete, and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by MCO.

L. Medicare Member Complaints. Provider agrees to cooperate with MCO in resolving any Medicare Member complaints related to coverage or the provision of Covered Services. MCO 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 MCO 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 Downstream Entities, if any, 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 the Medicare Plan. Such compliance program shall be appropriate to the organization and operations of Provider and Provider's Downstream Entities and shall include:

(1) written compliance policies and standards of conduct that are comparable to Aetna's compliance policies/Aetna Code of Conduct and articulate the entity's commitment to comply with federal and state laws, ethical behavior, and compliance program operations. Provider will disseminate either Aetna's compliance policies/Aetna Code of Conduct or comparable versions to Provider's employees, officers, and Downstream Entities within 90 days of hire/contracting, when updates are made, and annually thereafter;

(2) reporting mechanisms communicated to Provider's employees and Downstream Entities for their use in adhering to the expectation that Provider, its employees, and its Downstream Entities report potential non-compliance or FWA issues (internally and to MCO, as applicable) and understand their obligation to report. Provider must publicize the reporting methods to Provider employees and Downstream Entities along with a no-tolerance policy for retaliation or retribution for good-faith reporting;

(3) completion of CMS's Medicare Learning Network® (MLN) "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training" by Provider employees, officers, and Downstream Entities initially within ninety (90) days of hire/contracting and at least annually thereafter, unless exempt from such training under relevant CMS regulations;

(4) processes to oversee and ensure that Provider and Provider's Downstream Entities maintain compliance with processes to oversee and ensure that: (1) Provider and Provider's Downstream Entities maintain compliance with CMS compliance program requirements, and (2) Provider's Downstream Entities perform Medicare Services consistent with this Agreement and the agreement between Provider and such Downstream Entities. Provider's oversight under this Agreement shall include: (1) imposition of disciplinary actions, as needed, to ensure employee compliance with CMS compliance program requirements, and (2) implementation of corrective actions (up to and including contract termination), as needed, with respect to its Downstream Entities to ensure Downstream Entity compliance with applicable CMS requirements, including the CMS compliance program requirements, this Agreement, and Provider's contract with the Downstream Entity; and

(5) retention of evidence showing that Provider and Provider's Downstream Entities complied with the requirements set forth in this Section. Such evidence must be maintained for at least the period of time specified in Section B.5.F. hereof and shall be made available to MCO and CMS, upon request.

N. Marketing. Consistent with federal laws, regulations, and agency requirements applicable to the Medicare program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare Members, 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 are not responsible for paying to Provider any Copayments, Coinsurance, or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when, as applicable, either the State Medicaid plan or MCO (as the State's managed-care organization) is responsible for such Cost Sharing Amounts. Provider further agrees that it will not collect Cost Sharing Amounts from Medicare Members when, as applicable, either the State Medicaid plan or MCO (as the State's managed-care organization) is responsible for such Cost Sharing Amounts, and will instead accept the responsible party's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts.

P. Enrollment as Medicare Provider. To the extent that Provider prescribes drugs covered under Medicare Part D to Medicare Members who have Medicare prescription drug ("MA-PD") coverage offered by MCO, Provider agrees to comply with the requirements set forth in 42 C.F.R. § 423.120(c)(6), including without limitation the requirement that Provider be enrolled in Medicare in an approved status in order for its prescriptions to be covered under Medicare Part D.

Q. Home Infusion Drugs. The following provisions shall only apply to Provider if Provider dispenses to a Medicare Member home infusion drugs that are covered under Medicare Part D and the Medicare Member has MA-PD coverage offered by MCO ("Home Infusion Drug"):

1. With respect to Home Infusion Drugs, MCO will pay clean claims (as defined in 42 C.F.R. § 423.520(b)) submitted by Provider on behalf of Medicare Members within 14 days for electronic claims and within 30 days for claims submitted otherwise. 42 C.F.R. § 423.505(i)(3)(vi).

2. Home Infusion Drugs will be reimbursed (as applicable) in accordance with a fee schedule, or the third-party pricing source (*e.g.*, Medi-Span) otherwise agreed upon as set forth in this Agreement or Provider's agreement with MCO's Pharmacy Benefit Manager ("PBM"). 42 C.F.R. § 423.505(i)(3)(viii)(B).

3. If a prescription drug pricing standard is used for reimbursement of Home Infusion Drugs, updates to such a standard will occur not less frequently than once every 7 days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the Home Infusion Drug. 42 CFR § 423.505(i)(3)(viii)(A).

4. In accordance 42 C.F.R.§ 423.120(c)(3), Provider agrees to submit claims for Home Infusion Drugs to MCO or its PBM whenever the Medicare Member's ID card is presented or is on file at the Provider, unless the Medicare Member expressly requests that the claim not be submitted to MCO or its PBM.

5. Provider must submit claims for Home Infusion Drugs in real time by means of point of service claims adjudication systems in compliance with CMS standards. 42 C.F.R. § 423.505(b)(17).

6. Provider must provide Medicare Members with access to the negotiated prices (as defined in 42 C.F.R. § 423.100) for Home Infusion Drugs to Members. 42 C.F.R. § 423.104(g)(1).

7. Provider must charge/apply the correct cost-sharing amount to the Medicare Member for Home Infusion Drugs. 42 C.F.R. § 423.104.

8. At the time of purchase by a Medicare Member, Provider must inform the Medicare Member of any differential between the price of the Home Infusion Drug being dispensed and the price of the lowest priced generic version of that Home Infusion Drug available from Provider, unless the Home Infusion Drug being dispensed is the lowest priced generic version of that Home Infusion Drug. 42 C.F.R. § 423.132.

9. Provider agrees to ensure that the professional services and ancillary supplies necessary for Home Infusion Drugs are in place before dispensing Home Infusion Drugs to a Medicare Member in his/her place of residence. 42 C.F.R. § 423.120(a)(4)(iii).

10. Provider agrees to provide delivery of Home Infusion Drugs within 24 hours of a Medicare Member's discharge from an acute setting, or later if so prescribed. 42 C.F.R. § 423.120(a)(4)(iv).

11. Provider shall submit to MCO (not PBM) claims for equipment, supplies, and professional services associated with Home Infusion Drugs dispensed by Provider to a Medicare Member that are covered under Medicare Part C.

R. Non-Covered Services. Provider shall not hold a Member financially responsible for payment of a service not covered under the Member's Plan ("Non-Covered Service") unless the Member has received a pre-service organization determination notice of denial from MCO before such services are rendered. Provider

acknowledges and agrees that if Provider renders Non-Covered Services to a Member who has not received a pre-service organization determination notice of denial from MCO, the Provider must hold the Member harmless for the Non-Covered Services and cannot charge the Member any amount beyond the normal cost-sharing amounts (*i.e.*, copayments, coinsurance, and/or deductibles). With respect to those Non-Covered Services that are clearly listed as exclusions in the Member's Evidence of Coverage or other similar Plan document, a pre-service organization determination is not required in order for Provider to hold the Member financially liable for such Non-Covered Services.

17. COMPANY OBLIGATIONS.

A. Fee Schedule. MCO shall arrange for Provider to be compensated for health care services rendered to Medicare Members in accordance with Section B.1 of this Duals Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(a)(1), MCO 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 Duals Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. § 422.500.

C. From time to time MCO may designate only certain Providers to take part in the provider delivery network for a particular product benefit plan(s).

18. GENERAL PROVISIONS

A. Termination. This Duals 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 and the Three-Way Contract. This Duals Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement and the Three-Way Contract.

B. Governing Law. This Duals Addendum shall be governed by federal laws, regulations, and agency requirements applicable to the Medicare program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare program occur, the new law, regulation, or agency requirement shall supersede to the extent required by any such later required changes.

C. Agreement Otherwise Unmodified. 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 Duals Addendum and the Agreement, the terms of this Duals Addendum shall govern and control.

D. Survival. All provisions of this Duals Addendum that 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.

D. Requirements Under the MMAI Three-Way Contract

The Three-Way Contract requires that specific additional terms and conditions be incorporated into the Agreement. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the requirements set forth in this **Section C** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract and the MMAI. With respect to the requirements set forth in this

Section C, any capitalized terms that are used but not defined herein shall have the meanings that are ascribed to them in the Three-Way Contract. Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. The delegated activities and reporting requirements for which Provider is responsible are contained in the Agreement. Provider shall ensure that it and its downstream and related entities perform all such delegated activities and reporting requirements in compliance with 42 C.F.R. §§ 422.504, 423.505, 438.6(l), and 438.230(b)(1), as applicable. [Appendix C, ¶ A of Three-Way Contract]

2. HHS, the Comptroller General, the State of Illinois Department of Healthcare and Family Services (the "Department"), the Department's Office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, and their designees, and other state and federal agencies with monitoring authority related to Medicare and Medicaid, have the right to audit, evaluate, and inspect any books, contracts, computer, or other electronic systems, including medical records and documentation, of Provider and its downstream and related entities, and the foregoing rights to inspect, evaluate, and audit any pertinent information for any particular contract period shall exist for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later. [Appendix C, ¶ B of Three-Way Contract]

3. Provider and its downstream and related entities shall not hold Enrollees liable for payment of any fees that are the obligation of MCO. [Appendix C, ¶ C.1 of Three-Way Contract]

4. Any services or other activity performed by Provider and/or its downstream and related entities shall be performed in accordance with the MCO's contractual obligations to CMS and the Department. [Appendix C, ¶ C.2 of Three-Way Contract]

5. MCO shall revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS, the Department, or the MCO determine that Provider and/or its downstream and related entities have not performed their delegated activities or reporting requirements satisfactorily. [Appendix C, ¶ C.4 of Three-Way Contract]

6. The performance of Provider and its downstream and related entities under the Agreement will be monitored by MCO on an ongoing basis and MCO may impose corrective action as necessary. [Appendix C, ¶ C.5 of Three-Way Contract]

7. Provider and its downstream and related entities agree to safeguard Enrollee privacy and confidentiality of Enrollee health records. [Appendix C, ¶ C.6 of Three-Way Contract]

8. Provider and its downstream and related entities must comply with all federal and state laws, regulations, and CMS instructions. [Appendix C, ¶ C.7 of Three-Way Contract]

9. To the extent that Provider and/or its downstream and related entities provide credentialing of medical providers under the Agreement:

   A. The credentials of medical professionals affiliated with the Provider and/or its downstream and related entities will be reviewed by MCO; or

   B. The credentialing process will be reviewed and approved by MCO and MCO shall audit the credentialing process on an ongoing basis.

[Appendix C, ¶ D of Three-Way Contract]

10. To the extent that MCO has delegated the selection of providers under the Agreement to Provider or its downstream and related entities, MCO retains the right to approve, suspend, or terminate that arrangement. [Appendix C, ¶ E of Three-Way Contract]

11. MCO has the right to terminate its contract with Provider with cause upon sixty (60) days' notice, and without cause upon 120 days' notice, and Provider shall assist with transitioning Enrollees to new providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the MCO or Enrollee. If a for-cause termination, MCO must have an internal grievance procedure that allows Provider to contest the grounds for the termination prior to the effective date of the termination. [Appendix C, ¶ F of Three-Way Contract]

12. MCO shall provide a written statement to Provider of the reason or reasons for termination for cause. [Appendix C, ¶ G of Three-Way Contract]

13. MCO is obligated to pay Provider under the terms of the Agreement, which includes a prompt-payment provision that has been developed and agreed to by both MCO and Provider. [Appendix C, ¶ H.1 of Three-Way Contract]

14. Provider and its downstream and related entities shall provide all services under the Agreement in a Culturally Competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds. [Appendix C, ¶ H.2 of Three-Way Contract]

15. Provider and its downstream and related entities shall abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. [Appendix C, ¶ H.3 of Three-Way Contract]

16. Provider and its downstream and related entities shall ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas. [Appendix C, ¶ H.4 of Three-Way Contract]

17. Provider and its downstream and related entities shall maintain Enrollee records and information in an accurate and timely manner. [Appendix C, ¶ H.5 of Three-Way Contract]

18. Provider and its downstream and related entities shall ensure timely access by Enrollees to the records and information that pertain to them. [Appendix C, ¶ H.6 of Three-Way Contract]

19. Provider and its downstream and related entities shall not hold Enrollees liable for Medicare Part A and B cost sharing, and all Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees. [Appendix C, ¶ H.7 of Three-Way Contract]

20. Provider and its downstream and related entities shall ensure that their EMTALA obligations are fulfilled as required by law and the Agreement and must not create any conflicts with any hospital actions required to comply with EMTALA. [Appendix C, ¶ H.8 and Section 2.9.9.1 of Three-Way Contract]

21. Provider and its downstream and related entities, including without limitation all primary care providers, shall not close or otherwise limit acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees. [Appendix C, ¶ H.9 of Three-Way Contract]

22. MCO shall not refuse to contract or pay Provider for the provision of Covered Services solely because Provider has in good faith:

(a) Communicated with or advocated on behalf of one or more of the prospective, current, or former patients of Provider or its downstream and related entities regarding the provisions, terms, or requirements of the MCO's health benefit plans as they relate to the needs of such patients; or

(b) Communicated with one or more of the prospective, current, or former patients of Provider or its downstream and related entities with respect to the method by which such provider is compensated by the MCO for services provided to the patient.

[Appendix C, ¶ H.10 of Three-Way Contract]

23. Provider and its downstream and related entities are not required to indemnify MCO for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against MCO based on MCO's management decisions, utilization review provisions, or other policies, guidelines, or actions. [Appendix C, ¶ H.11 of Three-Way Contract]

24. Provider and its downstream and related entities shall comply with all MCO's requirements and MCO Policies for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services. [Appendix C, ¶ H.12 of Three-Way Contract]

25. MCO shall notify Provider in writing of modifications in payments, modifications in Covered Services or modifications in MCO's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 30 calendar days before the effective date of such modification unless such other date for notice is mutually agreed upon between MCO and Provider or unless such change is mandated by CMS or the Department without 30 calendar days' prior notice. [Appendix C, ¶ H.13 of Three-Way Contract]

26. Provider must comply with all Enrollee payment restrictions, including balance billing restrictions, and MCO may revoke or impose other specified remedies against Provider if Provider does not comply with such provisions. [Appendix C, ¶ H.14 of Three-Way Contract]

27. Provider and its downstream and related entities shall not bill Enrollees for charges for Covered Services other than pharmacy co-payments, if applicable. [Appendix C, ¶ H.15 of Three-Way Contract]

28. No payment shall be made by MCO to Provider, and Provider shall not seek payment from MCO, for a Provider Preventable Condition as defined in 42 C.F.R. § 447.26(b), and Provider shall, as a condition of payment from MCO, comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by MCO and/or the Department. [Section 2.7.3.2 and Appendix C, ¶¶ H.16 and H.17 of Three-Way Contract]

29. To the extent Provider is a Primary Care Physician or a specialty provider, Provider shall ensure coverage for its practice twenty-four (24) hours a day, seven (7) days a week and have a published after-hours telephone number; voicemail alone after hours is not acceptable. [Section 2.9.2.1 and 2.10.4.1 of Three-Way Contract]

30. MCO shall monitor and ensure that all Utilization Management activities provided by Provider comply with all provisions of the Three-Way Contract, and Provider and its downstream and related entities shall cooperate with and utilize MCO's quality assurance program. [Section 2.13.2.1.2.2 and Appendix C, ¶ H.18 of Three-Way Contract]

31. Provider shall not bill Enrollees for missed appointments or refuse to provide services to Enrollees who have missed appointments. Providers must work with Enrollees and MCO to assist Enrollees in keeping their appointments. [Appendix C, ¶ H.19 of Three-Way Contract]

32. Provider shall not refuse to provide services to an Enrollee because the Enrollee has an outstanding debt with the Provider from a time prior to the Enrollee becoming a member. [Appendix C, ¶ H.20 of Three-Way Contract]

33. Provider shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. Contracts or arrangements with First Tier, Downstream and Related Entities shall not include incentive plans that include a specific payment to Provider or its downstream and related entities as an inducement to deny, reduce, delay, or limit specific, Medically Necessary Services, and (a) Provider and/or its downstream and related entities shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate, and (b) MCO shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate. Nothing herein shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared-risk agreements that are made with respect to physicians or physician groups or that are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services, and equipment provided or authorized by another physician or health care provider, comply with Paragraph 34 immediately below. [Appendix C, ¶¶ H.14 and I, and Section 5.1.7 of Three-Way Contract]

34. MCO shall not impose a financial risk on Provider or its downstream and related entities for the costs of medical care, services, or equipment provided or authorized by another Physician or health care provider unless such contract includes specific provisions with respect to the following:

A. Stop-loss protection;

B. Minimum patient population size for the Physician or Physician group; and

C. Identification of the healthcare services for which Physician or Physician group is at risk.

[Appendix C, ¶ J of Three-Way Contract]

35. All contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites that provide services must include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. [Appendix C, ¶ K of Three-Way Contract]

36. Nothing shall be construed to restrict or limit the rights of MCO to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious nonmedical providers. [Appendix C, ¶ L of Three-Way Contract]

37. Provider shall meet all terms and requirements of the Three-Way Contract that are applicable to Provider. [Section 2.7.2.2.1 of Three-Way Contract]

38. Provider will collaborate with MCO on documentation systems reporting, communications, policies, and any other matters necessary for any readiness review required under the Three-Way Contract. [Section 2.2.1 of Three-Way Contract]

39. Provider shall collaborate with MCO, as requested and required under the Three-Way Contract, on activities relating to Care Coordination and the Enrollee Care Plans. [Section 2.5 of Three-Way Contract]

40. As requested and required under the Three-Way Contract, Provider shall actively participate as a member of the Interdisciplinary Care Team, and shall collaborate with the Enrollee and other members of the Interdisciplinary Care Team to perform the functions and tasks that are required of the Interdisciplinary Care Team under the Three-Way Contract. [Section 2.5.2 of Three-Way Contract]

41. Provider must maintain locations that are accessible to Enrollees with disabilities and that are ADA compliant. [Section 2.8.1.4 of Three-Way Contract]

42. Provider shall be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollee with disabilities (both congenital and acquired disabilities), or other special population served by the MCO. [Section 2.7.1.6 of Three-Way Contract]

43. To the extent that Provider is multilingual, Provider shall understand and comply with its obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Provider to meet these obligations. [Section 2.7.1.8 of Three-Way Contract]

44. Provider shall maintain a strong understanding of disability culture and **Long Term Supports and Services**. [Section 2.7.1.14 of Three-Way Contract]

45. To the extent that Provider provides Medicare-covered services, Provider shall be enrolled as a Medicare provider in order to submit claims for reimbursement or otherwise participate in the Medicare program. To the extent that Provider provides Medicaid-covered services, Provider shall be enrolled in the Illinois Medicaid program, if such enrollment is required by the Department's rules or policy, in order to submit claims for reimbursement or otherwise participate in the Illinois Medicaid program. [Section 2.8.1.2 of Three-Way Contract]

46. If a Provider provides any Emergency Services to an Enrollee, the Provider must promptly notify the Enrollee's Primary Care Physician of the Enrollee's screening and treatment. [Section 2.9.8.1.7 of Three-Way Contract]

47. If any Grievance or Appeal is filed with Provider, Provider must immediately forward it to MCO. [Section 2.11.1.1 of Three-Way Contract]

48. Provider must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) as outlined in the Three-Way Contract, and must maintain capacity to deliver services in a manner that reasonably accommodates the needs of Enrollees. [Section 2.9.1.6 of Three-Way Contract]

49. Upon MCO's request, Providers must provide the following information: (a) its name, address, and telephone number; (b) its areas of special experience, skills and training, including any expertise in treating the MMAI population; (c) its office hours, including the name of any provider site open after 5:00 p.m. (Eastern Time) weekdays and/or open on weekends; (d) its cultural and linguistic capabilities, including languages spoken by the Provider or by any skilled medical interpreter at the Provider's site; (e) Provider licensing information; (f) whether it is accessible for people with physical disabilities; (g) whether it is accepting new patients; (h) whether it is accessable by public transportation; and (h) any languages other than English spoken by Provider or by skilled medical interpreters at Provider's site, and whether translation services are available. [Section 2.14.5.2 of Three-Way Contract]

50. As requested and required, Provider must provide any information that CMS and/or the Department require (a) under the Three-Way Contract related to the performance of MCO's responsibilities, including non-medical information for the purposes of research and evaluation; (b) to comply with all applicable federal or state laws and

regulations; and (c) for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Grievances and Appeals and enrollment/disenrollment rates. [Section 2.16.1 of Three-Way Contract]

51. Collaborate with MCO in the collection and maintenance of all Encounter Data for all Covered Services that Provider provides to Enrollees, ensuring that all such data can be linked to the Department eligibility data. [Section 2.17 of Three-Way Contract]

52. In connection with the MMAI, Provider shall act in an independent capacity and not as an officer, employee, or agent of the federal government or the State of Illinois. [Section 5.1.3.1 of Three-Way Contract]

53. Provider shall not have any interest that will conflict, as determined by CMS and the Department, with the performance MCO's services under the Three-Way Contract, including without limitation any financial, legal, contractual or other business interest in any entity performing enrollment functions for the Department. [Section 5.3.17 of Three-Way Contract]

54. If requested by the State of Illinois in response to a background check of any officer, employee, or agent of the Provider, the Provider shall immediately reassign any such individual who, in the opinion of the State of Illinois, does not pass the background check. [Section 5.3.21.1 of Three-Way Contract]

55. Provider is prohibited from giving gifts to Department employees, and from giving gifts to, or accepting gifts from, any person who has a contemporaneous contract with the Department involving duties or obligations related to the Three-Way Contract. [Section 5.3.21.8 of the Three-Way Contract]

56. As requested by MCO, Provider shall submit disclosures in accordance with 42 C.F.R. § 455 and 42 C.F.R. § 1002.3. [Section 5.1.6 of Three-Way Contract]

57. Provider shall notify MCO immediately if Provider has lost any required license or state or federal approval, or has been excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 *et seq.* [Sections 2.7.1.3 and 5.3.4 of Three-Way Contract]

58. Provider and its downstream and related entities shall allow MCO to access the medical records of Enrollees. [Section 2.13.4.2.3 of Three-Way Contract]

59. If the Provider is discharging an Enrollee from a hospital, Provider must assure that the Enrollee receives a written notice of explanation called an "Important Message from Medicare About your Rights" regarding the right to appeal the discharge decision from an inpatient hospital admission. [Section 2.12.7.1 of Three-Way Contract]

60. Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees. [Section 2.8.6 of Three-Way Contract]

61. Provider must be appropriately and continually licensed or certified, as applicable, pursuant to federal and statement requirements. [Section 2.7.2.2.4 of Three-Way Contract]

62. Provider shall conduct all activities in accordance with the Enrollee rights and protections set forth under

42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and Appendix B ("Enrollee Rights") of the Three-Way Contract. [Appendix B of Three-Way Contract]

63. Provider may not reuse or provide other entities access to the CMS or Illinois information systems, or data obtained from the CMS or Illinois information systems, to support any line of business other than the MMAI for which the MCO contracted with CMS and the State of Illinois. [Appendix F of Three-Way Contract]

64. Provider acknowledges and agrees that compliance with Sections 5.3.22 through 5.3.32 of the Three-Way Contract and each subsection thereof (collectively, the "Standard Certifications") is a material requirement and condition of this Agreement during the entire term thereof, including during any renewal periods. By executing the Agreement, Provider certifies compliance with the Standard Certifications in their entirety, and Provider is under a continuing obligation to remain in compliance with, and to report any non-compliance with respect to, the Standard Certifications. Furthermore, Provider shall include the Standard Certifications in any subcontracts or other contracts with downstream entities or related entities that Provider enters into with respect to the provision of Covered Services to Enrollees dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, including the performance of any activities delegated to Provider in connection with the Three-Way Contract and the MMAI; if the Agreement extends over multiple fiscal years, including the initial term and all renewals, Provider and any such subcontractors, downstream entities, or related entities shall confirm compliance with the Standard Certifications in the manner and format determined by the State of Illinois by the date specified by the State of Illinois, and in no event later than July 1 of each year that the Agreement remains in effect.

If the Parties determine that any Standard Certification is not applicable to the Agreement, such Standard Certification may be stricken without affecting the remaining Standard Certifications.

As part of each Standard Certification, Provider acknowledges and agrees that if Provider or its subcontractors, downstream entities, or related entities provide false information, or fail to be or remain in compliance with the Standard Certifications, one or more of the following sanctions will apply: (a) the Agreement may be void by operation of law; (b) the State of Illinois may void the Agreement; and (c) the Provider and its subcontractors, downstream entities, or related entities may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty. Identifying a sanction or failing to identify a sanction in relation to any of the Standard Certifications does not waive imposition of other sanctions or preclude application of sanctions not specifically identified.

a. Provider certifies it and its employees will comply with applicable provisions of the United States Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101, *et seq.*), and applicable rules in performance of this Agreement.

b. Provider certifies, if applicable, that it is a properly formed and existing legal entity (30 ILCS 500/1.15.80, 20-43); and as applicable has obtained an assumed name certificate from the appropriate authority, or has registered to conduct business in Illinois and is in good standing with the Illinois Secretary of State.

c. Provider certifies it has neither been convicted of bribing or attempting to bribe an officer or employee of the State of Illinois or any other state, nor made an admission of guilt of such conduct that is a matter of record. 30 ILCS 500/50-5.

d. If Provider employs twenty-five (25) or more employees and the Agreement is worth more than $5,000, Provider certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580).

e. Provider certifies that neither Provider nor any substantially owned affiliate of Provider is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce. This applies to contracts that exceed

$10,000 (30 ILCS 582).

f. Provider certifies that it has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33E-3, E-4).

g. Provider certifies that it complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105).

h. Provider warrants and certifies that it and, to the best of its knowledge, its subcontractors, downstream entities, or related entities, have and will comply with Executive Order No. 1 (2007). That Order generally prohibits contractors and subcontractors from hiring the then-serving Illinois Governor's family members to lobby procurement activities of the State of Illinois, or any other unit of government in Illinois including local governments if that procurement may result in a contract valued at over $25,000. This prohibition also applies to hiring for that same purpose any former State of Illinois employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity.

i. Provider certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal or state department or agency, and is not currently barred or suspended from contracting with the State of Illinois under Section 50-35(f), 50-35(g) or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 *et seq.* If at any time during the term of this Agreement, Provider becomes barred, suspended, or excluded from participation in this transaction, Provider shall, within thirty (30) days after becoming barred, suspended, or excluded, provide to the Department a written description of each offense causing the exclusion, the date(s) of the offense, the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence complete.

j. Provider certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Provider shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such form is to be obtained at Provider's request from the Department's Bureau of Fiscal Operations. Provider shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this Agreement was executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Exhibit A— 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 (or its Affiliate, as the case may be) and Provider (referred to in this Schedule 1 as "FDR") not inconsistent herein shall remain in full force and effect. This Amendment 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. Required Provisions:

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's contract with Company (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)]

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:

(i) The delegated activities and reporting responsibilities are specified as follows:

[To be specified if applicable]

(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.

[To be specified if applicable]

(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.

[To be specified if applicable]

(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.

Individual Sites Regulatory Addendum – Exhibit A

Texas Medicaid Regulatory Compliance Addendum – Provider

This Texas Medicaid Compliance Addendum ("Addendum") is incorporated by reference into the Agreement and applies to Medicaid and CHIP products, including STAR Kids and the eligible populations covered by the State Contract.

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 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. Capitalized terms used and not otherwise defined in this Addendum shall have the meanings set forth in the Agreement or, if not defined in the Agreement, in the State Contract(s) or under Texas Law.

I. Texas Medicaid Managed Care Required Provisions

The State Contract mandates that Company's provider agreements, including the Agreement, include mandatory provisions included in the Texas Health and Human Services Commission's ("HHSC") Uniform Managed Care Manual, Chapter 8.1, "Provider Contract Checklist" (UMCM, Chapter 8.1). Company's Provider Manual and all amendments to the Provider Manual are incorporated by reference into the Agreement.

A. Access to Records. Provider agrees to provide to HHSC, at no cost:

1. All information required under Company's managed care contract with HHSC, including, but not limited to, the reporting requirements and other information related to the provider network, Provider's performance of its obligations under the Agreement; and
2. Any information in Provider's possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules and regulations.

All information must be provided in accordance with the timelines, definitions, formats and instructions specified by HHSC. [CHIP, Uniform Managed Care Contract (UMCC), Att. B-1, § 8.1.20, CHIP Rural Service Area Contract (RSA), Att. B-1, § 8.1.20; STAR, UMCC, Att. B-1 § 8.1.20; STAR+PLUS, UMCC, Att. B-1 § 8.1.20, STAR+PLUS Expansion Contract (S+P Ex.), Att. B-1, § 8.1.20, STAR+PLUS Medicaid Rural Service Area (S+P MRSA), Att. B-1, § 8.1.22; STAR Health, Att. B-1 § 8.1.26; STAR Kids, Att. B-1 § 8.1.22]

Upon receipt of a record review request from the HHSC Office of Inspector General (OIG) or another state or federal agency authorized to conduct compliance, regulatory or program integrity functions, Provider must provide, at no cost to the requesting agency, the records requested within three (3) business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request or in less than 24 hours, Provider must provide the records requested at the time of the request or in less than 24 hours. The request for record review includes clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, and charting; billing records, invoices, documentation of delivery items, equipment or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical

documentation; computer records and data; and/or contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining and securing custody of the records may result in OIG imposing sanctions against Provider as described in 1 Tex. Admin. Code, Chapter 371, Subchapter G. [CHIP, UMCC, Att. B-1, § 8.1.19, RSA, Att. B-1, § 8.1.19; STAR, UMCC, Att. B-1 § 8.1.19; STAR+PLUS, UMCC, Att. B-1 § 8.1.19, S+P Ex., Att. B-1, § 8.1.19, S+P MRSA, Att. B-1, § 8.1.21; STAR Health. Att. B-1 § 8.1.25; STAR Kids, Att. B-1 § 8.1.21]

B. **Administrative Requirements**. Provider must inform both Company and HHSC's administrative services contractor of any changes to Provider's address, telephone number, group affiliation, etc. [CHIP, UMCM, Ch. 3.3; STAR, UMCM, Ch. 3.3; STAR+PLUS, UMCM, Ch. 3.3; STAR Health, UMCM, Ch. 3.14; STAR Kids, UMCM, Ch. 3.34]

C. **Advance Directives**. Provider must comply with the requirements of applicable state and federal laws, rules and regulations relating to advance directives for all STAR, STAR+PLUS, STAR Health or STAR Kids Members. [STAR, UMCC, Att. B-1 § 8.2.11; STAR+PLUS, UMCC, Att. B-1 § 8.2.11, S+P Ex., Att. B-1, § 8.1.32, S+P MRSA, Att. B-1, § 8.1.34; STAR Health, Att. B-1 § 8.1.34.1; STAR Kids, Att. B-1 § 8.1.35]

D. **Audit or Investigation**. Provider agrees to provide, at no cost, the following entities or their designees with prompt, reasonable and adequate access to the Agreement and any records, books, documents and papers that are related to the Agreement and/or Provider's performance of its responsibilities under the Agreement:

1. The United States Department of Health and Human Services or its designee;
2. The Comptroller General of the United States or its designee;
3. Company personnel from HHSC or its designee;
4. The Office of Inspector General;
5. The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
6. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;
7. The Office of the State Auditor of Texas or its designee;
8. A State or Federal law enforcement agency;
9. A special or general investigating committee of the Texas Legislature or its designee; and
10. Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

Provider must provide access wherever it maintains such records, books, documents and papers. Provider must provide such access in reasonable comfort and provide any furnishings, equipment and other conveniences deemed reasonably necessary to fulfill the purposes described herein.

Requests for access may be for, but are not limited to, the following purposes:

1. examination;
2. audit;
3. investigation;
4. contract administration;
5. the making of copies, excerpts or transcripts; or
6. any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.

Provider understands and agrees that the acceptance of funds under this contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost.

[CHIP, UMCC, Att. A, §§ 9.02, 9.04, RSA, Att. A, §§ 9.02, 9.04; STAR, UMCC, Att. A, §§ 9.02, 9.04; STAR+PLUS, UMCC, Att. A, §§ 9.02, 9.04, S+P Ex., Att. A, §§ 9.02, 9.04, S+P MRSA, Att. A, §§ 9.02, 9.04; STAR Health, Att. A, §§ 9.02, 9.05; STAR Kids, Att. A, § 9.05 & Att. B-1 § 9.02]

E. Behavioral Health

1. Providers who are Primary Care Physicians (PCPs) must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. [CHIP, UMCC, Att. B-1, § 8.1.15.4, RSA, Att. B-1, § 8.1.15.4; STAR, UMCC, Att. B-1 § 8.1.15.4; STAR+PLUS, UMCC, Att. B-1 § 8.1.15.4, S+P Ex., Att. B-1, § 8.1.15.4, S+P MRSA, Att. B-1, § 8.1.15.4; STAR Health, Att. B-1 § 8.1.17.4; STAR Kids, Att. B-1 § 8.1.16.3]
2. Providers who provide inpatient psychiatric services to a Member must schedule the Member for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. Behavioral health providers must contact Members who have missed appointments within 24 hours to reschedule appointments. [CHIP, UMCC, Att. B-1, § 8.1.15.5, RSA, Att. B-1, § 8.1.15.5; STAR, UMCC, Att. B-1 § 8.1.15.5; STAR+PLUS, UMCC, Att. B-1 § 8.1.15.5, S+P Ex., Att. B-1, § 8.1.15.5, S+P MRSA, Att. B-1, § 8.1.15.5; STAR Health, Att. B-1 § 8.1.17.5; STAR Kids, Att. B-1 § 8.1.16.4]

F. **Cancellation of Product Orders**. If Provider offers delivery services for covered products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products, Provider must reduce, cancel or stop delivery if the Member or the Member's authorized representative submits an oral or written request. Provider must maintain records documenting the request. [CHIP, UMCC, Att. B-1, § 8.1.27, RSA, Att. B-1, § 8.1.27; STAR, UMCC, Att. B-1 § 8.1.27; STAR+PLUS, UMCC, Att. B-1 § 8.1.27, S+P Ex., Att. B-1, § 8.1.44, S+P MRSA, Att. B-1, § 8.1.16.7; STAR Health, Att. B-1 § 8.1.21; STAR Kids, Att. B-1 § 8.1.17.17]

G. Claims Payment

1. The process for payment of claims applicable to the Agreement is set forth in Company's Provider Manual. Information required for the submission of a clean claim is described in the main body of the Agreement and in Company's Provider Manual. Provider's rate of compensation is identified in the Services and Compensation Schedule to the Agreement. Where compensation is based on the Texas Medicaid fee schedule, Provider may obtain information about the fee schedule by contacting Company at the address or telephone number listed in Company's Provider Manual. There is no charge for this information. [CHIP, UMCC, Att. B-1, §§ 8.1.4.8 & 8.1.18.5, RSA, Att. B-1, §§ 8.1.4.8 & 8.1.18.5; STAR, UMCC, Att. B-1 §§ 8.1.4.8 & 8.1.18.5; STAR+PLUS, UMCC, Att. B-1 §§ 8.1.4.8 & 8.1.18.5, S+P Ex., Att. B-1, §§ 8.1.4.8 & 8.1.18.5, S+P MRSA, Att. B-1, §§ 8.1.4.8 & 8.1.20.5; STAR Health, Att. B-1 §§ 8.1.4 & 8.1.24.5; STAR Kids, Att. B-1 § 8.1.20.5]

2. Notwithstanding anything in the Provider Manual to the contrary, Company shall pay clean claims for: (1) healthcare services within thirty (30) days from receipt; (2) pharmacy services no later than eighteen (18) days of receipt if submitted electronically or twenty-one (21) days of receipt if submitted non-electronically. Company will pay Provider interest at a rate of 18% per annum on all clean claims that are not adjudicated within thirty (30) days. [CHIP, UMCC, Att. B-1, § 8.1.18.5, RSA, Att. B-1, § 8.1.18.5; STAR, UMCC, Att. B-1 § 8.1.18.5; STAR+PLUS, UMCC, Att. B-1 § 8.1.18.5, S+P Ex., Att. B-1, § 8.1.18.5, S+P MRSA, Att. B-1, § 8.1.20.5; STAR Health, Att. B-1 § 8.1.24.5; STAR Kids, Att. B-1 § 8.1.20.5]

3. Provider must comply with the requirements of Texas Government Code § 531.024161 regarding the submission of claims involving supervised providers. [CHIP, UMCC, Att. B-1, § 8.1.18.1, RSA, Att. B-1, § 8.1.18.1; STAR, UMCC, Att. B-1 § 8.1.18.1; STAR+PLUS, UMCC, Att. B-1 § 8.1.18.1, S+P Ex., Att. B-1, § 8.1.18.1, S+P MRSA, Att. B-1, § 8.1.20.1; STAR Health, Att. B-1 § 8.1.24.1; STAR Kids, Att. B-1 § 8.1.20.1]

4. Provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding or other payment process and fee schedules applicable to specific procedures that Provider will receive under the Agreement. Company will provide the coding guidelines not later than thirty (30) days after receipt of the request. Company will provide notice of changes to the coding guidelines and fee schedule that will result in a change of payment not later than the 90th day before the date the change takes effect. Provider may terminate the Agreement in accordance with the termination provisions of the Agreement on or before the 30th day after Provider receives information requested without penalty or discrimination in participation in other health care products or plans. [CHIP, UMCC, Att. B-1, § 8.1.18.5, RSA, Att. B-1, § 8.1.18.5; STAR, UMCC, Att. B-1 § 8.1.18.5; STAR+PLUS, UMCC, Att. B-1 § 8.1.18.5, S+P Ex., Att. B-1, § 8.1.18.5, S+P MRSA, Att. B-1, § 8.1.20.5; STAR Health, Att. B-1 § 8.1.24.5; STAR Kids, Att. B-1 § 8.1.20.5; TEX. INS. CODE § 843.321]

5. A physician or provider who receives such information may only (1) use or disclose the information for the purpose of practice management, billing activities and other business operations; and (2) disclose the information to a governmental agency involved in the regulation of health care or insurance. [TEX. INS. CODE § 843.321]

6. Program violations arising out of performance of the Agreement are subject to administrative enforcement by the HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G. [CHIP, UMCC, Att. B-1, § 8.1.18.5, RSA, Att. B-1, § 8.1.18.5; STAR, UMCC, Att. B-1 § 8.1.18.5; STAR+PLUS, UMCC, Att. B-1 § 8.1.18.5, S+P Ex., Att. B-1, § 8.1.18.5, S+P MRSA, Att. B-1, § 8.1.20.5; STAR Health, Att. B-1 § 8.1.24.5; STAR Kids, Att. B-1 § 8.1.20.5]

H. Complaints and Appeals

1. Company's complaint and appeal processes applicable to Provider under the terms of the Agreement are set forth in Company's Provider Manual. [CHIP, UMCC, Att. B-1, § 8.4.1, RSA, Att. B-1, § 8.4.10; STAR, UMCC, Att. B-1 § 8.2.4; STAR+PLUS, UMCC, Att. B-1 § 8.2.4, S+P Ex., Att. B-1, § 8.1.25, S+P MRSA, Att. B-1, § 8.1.27; STAR Health, Att. B-1 § 8.1.31; STAR Kids, Att. B-1 § 8.1.27]

2. Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.

I. Confidentiality

1. Provider must treat all information that is obtained through the performance of the services included in the Agreement as confidential information to the extent that confidential treatment is provided under state and federal laws, rules and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs. [CHIP, UMCC, Att. A, § 11.01(a), RSA Att., A, § 11.01(a); STAR, UMCC, Att. A, § 11.01(a); STAR+PLUS, UMCC, Att. A, § 11.01(a), S+P Ex., Att. A, § 11.01(a), S+P MRSA, Att. A, § 11.01(a); STAR Health Att., A, § 11.01(a); STAR Kids, Att. A, § 11.01(a)]

2. Provider shall not use information obtained through the performance of the Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Agreement. [CHIP, UMCC, Att. A, § 11.01(c), RSA, Att. A, § 11.01(c); STAR, UMCC, Att. A, § 11.01(c); STAR+PLUS, UMCC, Att. A, § 11.01(c), S+P Ex., Att. A, § 11.01(c), S+P MRSA, Att. A, § 11.01(c); STAR Health, Att. A, § 11.01(c); STAR Kids, Att. A, § 11.01(c)]

3. Provider shall protect the confidentiality of Member Protected Health Information (PHI), including patient records. Provider must comply with all applicable federal and state laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of PHI. [CHIP, UMCC, Att. A, §§ 7.02, 7.07, 11.01, & 11.03(a), RSA, Att. A, §§ 7.02, 7.07, 11.01, & 11.03(a); STAR, UMCC, Att. A, §§ 7.02, 7.07, 11.01, & 11.03(a); STAR+PLUS, UMCC, Att. A, §§ 7.02, 7.07, 11.01, & 11.03(a), S+P Ex., Att. A, §§ 7.02, 7.07,

11.01, & 11.03(a), S+P MRSA, Att. A, §§ 7.02, 7.06, 11.01, & 11.03(a); STAR Health, Att. A, §§ 7.02, 7.06, 11.01, & 11.03(a); STAR Kids, Att. A, §§ 7.02, 7.06, 11.01, & 11.03(a)]

J. **Costs of Non-Covered Services**. Provider must inform Members of the cost for non-covered services prior to rendering such services and must obtain a signed Private Pay form from such a Member. [CHIP, UMCC, Att. B-1, § 8.1.23, RSA, Att. A, § 10.11(a)(7); STAR, UMCC, Att. B-1, § 8.1.23; STAR+PLUS, UMCC, Att. B-1, § 8.1.23, S+P Ex., Att. A, § 10.10, S+P MRSA, Att. A, § 10.10; STAR Health, Att. A, § 10.09; STAR Kids, Att. A, § 10.09]

K. **Durable Medical Equipment**. Please consult the Texas Medicaid Provider Procedures Manual, Durable Medical Equipment (DME) and Comprehensive Care Program (CCP) sections, and Company's Provider Manual under the heading "DURABLE MEDICAL EQUIPMENT AND OTHER PRODUCTS NORMALLY FOUND IN A PHARMACY" for information regarding the scope of coverage of durable medical equipment (DME) and other products commonly found in a pharmacy. For qualified children, this includes medically necessary over-the-counter drugs, diapers, disposable/expendable medical supplies, and some nutritional products. It also includes medically necessary nebulizers, ostomy supplies or bed pans, and other supplies and equipment for all qualified Members. Company encourages Provider's pharmacy's participation in providing these items to Medicaid clients. This section applies to STAR, STAR+PLUS, STAR Health and STAR Kids Members. [STAR, UMCC Att. B-1, § 8.1.21; STAR+PLUS, UMCC Att. B-1, § 8.1.21, S+P Ex. Att. B-1, § 8.1.42, S+P MRSA Att. B-1, § 8.1.16; STAR Health Att. B-1, § 8.1.20; STAR Kids Att. B-1, § 8.1.17]

L. **Early Childhood Intervention (ECI)**. Providers must cooperate and coordinate with local ECI programs to comply with federal and state requirements relating to the development, review and evaluation of Individual Family Service Plans (IFSP). Provider understands and agrees that any Medically Necessary Health and Behavioral Health Services contained in an IFSP must be provided to the Member in the amount, duration, scope and setting established in the IFSP. [CHIP, UMCC, Att. B-1, § 8.1.9, RSA, Att. B-1, § 8.1.9; STAR, UMCC, Att. B-1 § 8.1.9; STAR+PLUS, UMCC, Att. B-1 § 8.1.9, S+P Ex., Att. B-1, § 8.1.9, S+P MRSA, Att. B-1, § 8.1.9; STAR Health, Att. B-1 § 8.1.9; STAR Kids, Att. B-1 § 8.1.10]

M. **Electronic Visit Verification (EVV)**. Providers using the EVV system for services provided to STAR+PLUS, STAR Health or STAR Kids Members must maintain compliance with HHSC minimum standards detailed in the Uniform Managed Care Manual, Chapter 8.7, Section IX. [STAR+PLUS, UMCC, Att. B-1 § 8.2.17, S+P Ex., Att. B-1, § 8.1.33.3, S+P MRSA, Att. B-1, § 8.1.35.3; STAR Health, Att. B-1 § 8.1.37; STAR Kids, Att. B-1 § 8.1.36.1]

N. **Family Planning**

1. If a STAR, STAR+PLUS, STAR Health or STAR Kids Member requests contraceptive services or family planning services, Providers must also provide the Member counseling and education about family planning and available family planning services.

2. Provider cannot require parental consent for STAR, STAR+PLUS, STAR Health or STAR Kids Members who are minors to receive family planning services.

3. Provider must comply with state and federal laws and regulations governing STAR, STAR+PLUS, STAR Health or STAR KidsMember confidentiality (including minors) when providing information on family planning services to STAR, STAR+PLUS, STAR Health or STAR Kids Members.

[STAR, UMCC, Att. B-1 § 8.2.2.2; STAR+PLUS, UMCC, Att. B-1 § 8.2.2.2, S+P Ex., Att. B-1, § 8.1.22.2, S+P MRSA, Att. B-1, § 8.1.24.2; STAR Health, Att. B-1 § 8.1.28.2; STAR Kids, Att. B-1 § 8.1.24.2]

O. **Fraud and Abuse.** Provider understands and agrees to the following:

1. HHSC Office of Inspector General (OIG) and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Provider and its employees, agents, contractors and patients;

2. Requests for information from such entities must be complied with, in the form and language requested;

3. Provider and its employees, agents and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at Provider's own expense;

4. Compliance with these requirements will be at Provider's own expense;

5. Providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care and the Medicaid and/or CHIP Programs, as applicable;

6. Provider must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste;

7. Provider must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge;

8. If Provider places required records in another legal entity's records, such as a hospital, Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and

9. Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by Company or a Member, to the HHSC Office of Inspector General.

[CHIP, UMCC, Att. A, Art. 9; B-1, § 8.1.19, RSA, Att. A, Art. 9; B-1, § 8.1.19; STAR, UMCC, Att. A, Art. 9; B-1, § 8.1.19; STAR+PLUS, UMCC, Att. A, Art. 9; B-1, § 8.1.19, S+P Ex., Att. A, Art. 9; B-1, § 8.1.19, S+P MRSA, Att. A, Art. 9; B-1, § 8.1.21; STAR Health, Att. A, Art. 9; B-1, § 8.1.25; STAR Kids, Att. A, Art. 9; B-1, § 8.1.21]

If Provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), then Provider must:

1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act.

2. Include as part of such written policies detailed provisions regarding Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

[STAR, UMCC, Att. A, Art. 9; B-1, § 8.1.19; STAR+PLUS, UMCC, Att. A, Art. 9; B-1, § 8.1.19, S+P Ex., Att. A, Art. 9; B-1, § 8.1.19, S+P MRSA, Att. A, Art. 9; B-1, § 8.1.21; STAR Health, Att. A, Art. 9; B-1, § 8.1.25; STAR Kids, Att. A, Art. 9; B-1, § 8.1.21]

P. **Insurance.** Provider shall maintain, during the term of the Agreement, Professional Liability Insurance of at least $100,000 per occurrence and $300,000 in the aggregate, or, where applicable, the limits required by the hospital at which Provider has admitting privileges. This provision will not apply if Provider is a state or federal unit of government, or a municipality, that is required to comply with, and is subject to, the provisions of the Texas and/or Federal Tort Claims Act. [CHIP, UMCC, Att. A, § 17.01(b), RSA, Att. A, § 17.01(b); STAR, UMCC, Att. A, § 17.01(b); STAR+PLUS, UMCC, Att. A, § 17.01(b), S+P Ex., Att. A, § 17.01(b), S+P MRSA, Att. A, § 17.01(b); STAR Health, Att. A, § 17.01(b); STAR Kids, Att. A, § 17.01(b)]

Q. **Laws, Rules and Regulations.** Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements or other court orders that apply to the Agreement and Company's managed care contract with HHSC, the HMO Program, and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to the Agreement, or any violation of Company's contract with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law. [CHIP, UMCC, Att. A, § 7.02, RSA, Att. A, § 7.02; STAR, UMCC, Att. A, § 7.02; STAR+PLUS, UMCC, Att. A, § 7.02, S+P Ex., Att. A, § 7.02, S+P MRSA, Att. A, § 7.02; STAR Health, Att. A, § 7.02; STAR Kids Att. A, § 7.02]

Provider understands and agrees that the following laws, rules, regulations and all amendments or modifications thereto, apply to the Agreement:

1. Environmental protection laws:

    a. Pro-Children Act of 1994 (20 U.S.C. § 6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
    b. National Environmental Policy Act of 1969 (42 U.S.C. § 4321 et seq.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;
    c. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");
    d. State Clean Air Implementation Plan (42 U.S.C. § 740 *et seq.*) regarding conformity of federal actions to State Implementation Plans under § 176(c) of the Clean Air Act; and
    e. Safe Drinking Water Act of 1974 (21 U.S.C. § 349; 42 U.S.C. §§ 300f to 300j-9) relating to the protection of underground sources of drinking water;

2. State and federal anti-discrimination laws:

    a. Title VI of the Civil Rights Act of 1964, (42 U.S.C. § 2000d et seq.) and, as applicable, 45 C.F.R. Part 80 or 7 C.F.R. Part 15;
    b. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794);
    Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.);

    c. Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);
    d. Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688);
    e. Food Stamp Act of 1977 (7 U.S.C. § 200 et seq.);
    f. Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16; and
    g. The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to the Agreement;

3. The Immigration and Nationality Act (8 U.S.C. § 1101 et seq.) and all subsequent immigration laws and amendments;
4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and

5. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. § 17931 et seq.

[CHIP, UMCC, Att. A, §§ 7.04-7.07, RSA, Att. A, §§ 7.04-7.07; STAR, UMCC, Att. A, §§ 7.04-7.07; STAR+PLUS, UMCC, Att. A, §§ 7.04-7.07, S+P Ex., Att. A, §§ 7.04-7.07, S+P MRSA, Att. A, §§ 7.04-7.07; STAR Health, Att. A, §§ 7.04-7.06; STAR Kids, Att. A, §§ 7.04-7.06]

R. Lead Screening. In accordance with Texas Health and Safety Code Chapter 88 and related rules at 25 Tex. Admin. Code Chapter 37, Subchapter Q, for all STAR, STAR+PLUS, STAR Health or STAR Kids Members, Provider must (1) report all blood lead results to the Child Lead Poisoning Program (if not performed at the DSHS state laboratory) and (2) follow-up on suspected or confirmed cases of lead exposure with the Childhood Lead Poisoning Prevention Program, and follow the Centers for Disease Control and Prevention guidelines for testing children for lead and follow-up actions for children with elevated lead levels located at http://www.dshs.state.tx.us/lead/pdf_files/pb_109_physicain_reference.pdf. [STAR, UMCC, Att. B-1 §§ 8.2.2.3.1 & 8.2.10; STAR+PLUS, UMCC, Att. B-1 §§ 8.2.2.3.1 & 8.2.10, S+P Ex., Att. B-1, §§ 8.1.22.3.1 & 8.1.31, S+P MRSA, Att. B-1, §§ 8.1.24.3.1 & 8.1.33; STAR Health, Att. B-1 § 8.1.28.3.5; STAR Kids, Att. B-1 §§ 8.1.24.3 & 8.1,33]

S. Liability. In the event Company becomes insolvent or ceases operations, Provider understands and agrees that its sole recourse against Company will be through Company's bankruptcy, conservatorship, or receivership estate.

Provider hereby agrees that in no event, including, but not limited to, nonpayment by Company, Company's insolvency or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons other than Company acting on their behalf for Covered Services provided pursuant to the Agreement. [UMCM, Chapter 8.1, no. 44]. This provision shall not prohibit collection from a Member for any non-covered service and/or Copayment amounts in accordance with the terms of the applicable Member's health benefits and the Agreement. Provider further agrees that: (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member, or persons acting on their behalf.

Provider understands and agrees that HHSC does not assume liability for the actions of, or judgments rendered against, Company, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to Provider by Company or any judgment rendered against Company. HHSC's liability to Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (TEX. CIV. PRAC. & REM. CODE §101.001 *et seq.*). [CHIP, UMCC, Att. A, § 4.05, RSA, Att. A, § 4.05; STAR, UMCC, Att. A, § 4.05; STAR+PLUS, UMCC, Att. A, § 4.05, S+P Ex., Att. A, § 4.05, S+P MRSA, Att. A, § 4.05; STAR Health, Att. A, § 4.06; STAR Kids, Att. A, § 4.05]

T. Marketing. Provider agrees to comply with state and federal laws, rules and regulations governing marketing. In addition, Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in the HHSC/Company Managed Care Contract (which includes HHSC's Uniform Managed Care Manual). [CHIP, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3, RSA, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR+PLUS, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; S+P Ex., Att. B-1, § 8.1.6 & UMCM, Ch. 4.3, S+P MRSA, Att. B-1, § 8.16 & UMCM, Ch. 4.3; STAR Health, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR Kids, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3]

Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance. [CHIP, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3, RSA, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch.

4.3; STAR+PLUS, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3, S+P Ex., Att. B-1, § 8.1.6 & UMCM, Ch. 4.3, S+P MRSA, Att. B-1, § 8.16 & UMCM, Ch. 4.3; STAR Health, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR Kids, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3.]

U. **Company's Responsibility**. Company will initiate and maintain any action necessary to stop a Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Member to collect payment from HHSC, an HHS Agency, or any Member, excluding payment for non-covered services. This provision does not restrict a CHIP Provider from collecting allowable copayment and deductible amounts from CHIP Members. Additionally, this provision does not restrict a CHIP Dental Provider from collecting payment for services that exceed a CHIP member's benefit cap. [CHIP, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23, RSA, Att. A, §§ 4.05 & 10.12; STAR, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23; STAR+PLUS, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23, S+P Ex., Att. A, §§ 4.05 & 10.10, S+P MRSA, §§ 4.05 & 10.10; STAR Health, §§ 4.06 & 10.10; STAR Kids, §§ 4.05 & 10.09]

V. **Provider Network Requirements, Medicaid Agreements, TPI and NPI**. Network Acute Care Providers serving Medicaid Members must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid Program and must have a Texas Provider Identification Number (TPIN). All Providers, both CHIP and Medicaid, must have a National Provider Identifier (NPI). [CHIP, UMCC, Att. B-1, § 8.1.4, RSA, Att. B-1, § 8.1.4; STAR, UMCC, Att. B-1 § 8.1.4; STAR+PLUS, UMCC, Att. B-1 § 8.1.4, S+P Ex., Att. B-1, § 8.1.4, S+P MRSA, Att. B-1, § 8.1.4; STAR Health, Att. B-1 § 8.1.4; STAR Kids, Att. B-1 § 8.1.4]

W. **Member Communications**. Nothing contained in the Agreement is intended to interfere with or hinder communications between Provider and Member regarding a patient's medical condition and/or treatment options; Company referral policies and other Company policies, including financial incentives or arrangements; and all managed care plans with whom Provider contracts. [STAR, UMCC, Att. B-1 § 8.2.5; STAR+PLUS, UMCC, Att. B-1 § 8.2.5, S+P Ex., Att. B-1, § 8.1.26, S+P MRSA, Att. B-1, § 8.1.28; STAR Health, Att. B-1 § 8.1.32; STAR Kids, Att. B-1 § 8.1.28]

X. **Provider Reports of Abuse, Neglect or Exploitation**. Provider must inform Company of any reports of abuse, neglect, or exploitation made regarding a STAR+PLUS, STAR Health or STAR Kids Member. This includes Provider self-reports and reports made by others that Provider becomes aware of. [STAR+PLUS, UMCC, Att. A, Art. 2, Definitions & Att. B-1, §§ 8.1.4.6 & 8.3.12, S+P Ex., Att. A, Art. 2, Definitions & Att. B-1, §§ 8.1.4.6 & 8.1.52, S+P MRSA, Att. A, Art. 2, Definitions & Att. B-1, §§ 8.1.4.6 & 8.1.53; STAR Health, Att. A, Art. 2, Definitions, & Att. B-1, § 8.1.4.4.2; STAR Kids, Att. A, art. 2, Definitions & Att. B-1, § 8.1.4.4]

Y. **Payment for Services.** Provider is prohibited from billing or collecting any amount from a STAR, STAR+PLUS, STAR Health or STAR Kids Medicaid Member for Health Care Services provided pursuant to the Agreement. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service. [STAR, UMCC, Att. B-1 § 8.1.23; STAR+PLUS, UMCC, Att. B-1 § 8.1.23, S+P Ex., Att. A, § 10.10, S+P MRSA, Att. A, § 10.10; STAR Health, Att. A, § 10.09; STAR Kids, Att. A, § 10.09]

Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to the Agreement. [CHIP, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23, RSA, Att. A, §§ 4.05 & 10.12; STAR, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23; STAR+PLUS, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23, S+P Ex., Att. A, §§ 4.05 & 10.10, S+P MRSA, Att. A, §§ 4.05 & 10.10; STAR Health, Att. A, §§ 4.06 & 10.09; STAR Kids, Att. A, §§ 4.05 & 10.09]

Provider is responsible for collecting at the time of service any applicable CHIP co-payments in accordance with CHIP cost-sharing limitations.. Provider shall not charge: cost-sharing or deductibles to CHIP members of Native American Tribes or Alaskan Natives; co-payments to a CHIP Member with an ID card that indicates the Member has met his or her cost-sharing obligation for the balance of their term of coverage; co-payments for well-child or well-baby visits or immunizations (CHIP MCO and CHIP RSA); or co-payments for routine preventive and

diagnostic dental services (CHIP Dental). . Co-payments are the only amounts Provider may collect from CHIP Members except for costs associated with unauthorized non-emergency services provided to Member by out-of-network providers for non-covered services. [CHIP, UMCC, Att. B-1, § 8.1.23, RSA, Att. A, § 10.11 & Att. B-1, § 8.1.25]

Z. **Pharmacies.** If prior authorization for a medication is not immediately available, a 72-hour emergency supply may be dispensed when the pharmacist on duty recommends it as clinically appropriate and when the medication is needed without delay. Please consult the Vendor Drug Program Pharmacy Provider Procedures Manual, the Texas Medicaid Provider Procedures Manual, and Company's Provider Manual for information regarding reimbursement for 72-hour emergency supplies of prescription claims. It is important that pharmacies understand the 72-hour emergency supply policy and procedure to assist Medicaid clients. [CHIP, UMCC, Att. B-1, § 8.1.21.1, RSA, Att. B-1 § 8.1.24.1; STAR, UMCC, Att. B-1, § 8.1.21.1; STAR+PLUS, UMCC, Att. B-1, § 8.1.21.1, S+P Ex., Att. B-1 § 8.1.42.1, S+P MRSA, Att. B-1 § 8.1.16.2; STAR Health, Att. B-1 § 8.1.20.2; STAR Kids, Att. B-1 § 8.1.17.2]

AA. **Primary Care Physicians (PCPs).** PCPs must be accessible to Members 24 hours per day, 7 days per week. [CHIP, UMCC, Att. B-1, § 8.1.4, RSA Att. B-1 § 8.1.3; STAR, UMCC, Att. B-1, § 8.1.4; STAR+PLUS, UMCC, Att. B-1, § 8.1.4, S+P Ex., Att. B-1 § 8.1.4, S+P MRSA, Att. B-1 § 8.1.4; STAR Health, Att. B-1 § 8.1.4.2; STAR Kids, Att. B-1 § 8.1.4.10.1]

To the extent applicable, PCPs must provide preventative care:

1. to children under age 21 in accordance with AAP recommendations for CHIP Members and CHIP Perinatal Newborns, and the Texas Health Steps (THSteps) periodicity schedule published in the THSteps Manual for Medicaid Members and/or the Texas Medicaid Provider Procedures Manual; and
2. to adults in accordance with the U.S. Preventative Task Force requirements.
[CHIP, UMCC, Att. B-1, § 8.1.4.2, RSA, Att. B-1 § 8.1.3.1; STAR, UMCC, Att. B-1, § 8.1.4.2; STAR+PLUS, UMCC, Att. B-1, § 8.1.4.2, S+P Ex., Att. B-1 § 8.1.4.2, S+P MRSA, Att. B-1 § 8.1.4.2; STAR Health, Att. B-1 § 8.1.4.2; STAR Kids, Att. B-1 § 8.1.4.10.1]

PCPs must assess the medical needs and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Members' care with specialty care providers after referral. Also, PCPs must serve as a Medical Home to Members. [CHIP, UMCC, Att. A, Art. 2, "PCP" Definition & Att. B-1, § 8.1.4.2, RSA, Att. A, Art. 2, "PCP" Definition & Att. B-1, § 8.1.4.2; STAR, UMCC, Att. A, Art. 2, "PCP" Definition & Att. B-1, § 8.1.4.2; STAR+PLUS, UMCC, Att. A, Art. 2, "PCP" Definition & Att. B-1, § 8.1.4.2, S+P Ex., Att. A, Art. 2, "PCP" Definition & Att. B-1, § 8.1.4.2, S+P MRSA, Att. A, Art. 2, "PCP" Definition & Att. B-1 § 8.1.4; STAR Health, Att. A, Art. 2, "PCP" Definition & Att. B-1 § 8.1.4.2; STAR Kids, Att. A, Art. 2, "PCP" Definition & Att. B-1 § 8.1.4.10.1]

BB. **Professional Conduct**. While performing the services described in the Agreement, Provider agrees to:
1. comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and
2. otherwise conduct themselves in a businesslike and professional manner. [CHIP, UMCC, Att. A, § 4.07, RSA, Att. A, § 4.07; STAR, UMCC, Att. A, § 4.07; STAR+PLUS, UMCC, Att. A, § 4.07, S+P Ex., Att. A, § 4.07, S+P MRSA, Att. A, § 4.07; STAR Health, Att. A, § 4.08; STAR Kids, Att. A, § 4.07]

CC. **Quality Assessment and Performance and Improvement (QAPI).** Provider agrees to comply with Company's QAPI Program requirements. [CHIP, UMCC, Att. B-1, § 8.1.7, RSA, Att. B-1 § 8.1.7; STAR, UMCC, Att. B-1, § 8.1.7; STAR+PLUS, UMCC, Att. B-1, § 8.1.7, S+P Ex., Att. B-1 § 8.1.7, S+P MRSA, Att. B-1 § 8.1.7; STAR Health, Att. B-1 § 8.1.7; STAR Kids, Att. B-1 § 8.1.7]

DD. **Service Coordination.** All Home and Community Support Services Agency (HCSSA) providers, adult day care providers, and residential care facility providers must notify Company if a STAR +PLUS or STAR Kids

Member experiences any of the following: a significant change in the Member's physical or mental condition or environment; hospitalization; an emergency room visit; or two or more missed appointments. [

EE. Termination. The Agreement sets forth Company's process for terminating the Agreement. For CHIP HMOs and managed care organizations participating in the CHIP Perinatal Program, the process complies with the Texas Insurance Code § 843.306 and 28 Tex. Admin. Code § 11.901. [CHIP, UMCC, Att. B-1, § 8.1.4.9, RSA, Att. B-1 § 8.1.4.9; STAR, UMCC, Att. B-1, § 8.1.4.9; STAR+PLUS, UMCC, Att. B-1, § 8.1.4.9, S+P Ex., Att. B-1 § 8.1.4.9, S+P MRSA, Att. B-1 § 8.1.4.9; STAR Health, Att. B-1 § 8.1.4.10; STAR Kids, Att. B-1 § 8.1.4.7]

FF. Termination for Gifts or Gratuities. Provider may not offer or give any thing of value to an officer or employee of HHSC or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Company may terminate the Provider contract at any time for violation of this requirement. [CHIP, UMCC, Att. A, § 12.03(b)(5), RSA, Att. A, § 12.03(b)(5); STAR, UMCC, Att. A, § 12.03(b)(5); STAR+PLUS, UMCC, Att. A, § 12.03(b)(5), S+P Ex., Att. A, § 12.03(b)(5), S+P MRSA, Att. A, § 12.03(b)(5); STAR Health, Att. A, § 12.03(b)(5); STAR Kids, Att. A, § 12.03(b)(5)]

GG. Third-Party Recovery. Provider understands and agrees that it may not interfere with or place any liens upon the State's right or Company's right, acting as the State's agent, to recover from third party resources. [CHIP, UMCC, Att. B-1, § 8.4.3, RSA, Att. B-1 § 8.1.21; STAR, UMCC, Att. B-1, § 8.2.8; STAR+PLUS, UMCC, Att. B-1, § 8.2.8, S+P Ex., Att. B-1 § 8.1.29, S+P MRSA, Att. B-1 § 8.1.31; STAR Health, Att. B-1 § 8.1.34; STAR Kids, Att. B-1 § 8.1.31]

HH. THSteps. If applicable to STAR, STAR+PLUS, STAR Health or STAR Kids Members, Providers must send all THSteps newborn screens to the Texas Department of State Health Services (DSHS), formerly the Texas Department of Health, Bureau of Laboratories or a DSHS-certified laboratory. Providers must include detailed identifying information for all screened newborn Members and each Member's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up. [STAR, UMCC, Att. B-1, § 8.2.2.3; STAR+PLUS, UMCC, Att. B-1, § 8.2.2.3, S+P Ex., Att. B-1 § 8.1.22.3, S+P MRSA, Att. B-1 § 8.1.24.3; STAR Health, Att. B-1 § 8.1.28.3.3; STAR Kids, Att. B-1 § 8.1.24.3]

II. Tuberculosis. Providers must coordinate with the local TB control program to ensure that all STAR, STAR+PLUS, STAR Health or STAR Kids Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). Providers must report to DSHS or the local TB control program any Member who is non-compliant, drug-resistant, or who is or may be posing a public health threat. [STAR, UMCC, Att. B-1, § 8.2.2.6; STAR+PLUS, UMCC, Att. B-1, § 8.2.2.6, S+P Ex., Att. B-1 § 8.1.22.6, S+P MRSA, Att. B-1 § 8.1.24.6; STAR Health, Att. B-1 § 8.1.28.6; STAR Kids, Att. B-1 § 8.1.24.6]

JJ. Women, Infants and Children (WIC). Providers must coordinate with the Women, Infants and Children (WIC) Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. [CHIP, UMCC, Att. B-1, § 8.1.10, RSA, Att. B-1 § 8.1.10; STAR, UMCC, Att. B-1, § 8.1.10; STAR+PLUS, UMCC, Att. B-1, § 8.1.10, S+P Ex., Att. B-1 § 8.1.10, S+P MRSA, Att. B-1 § 8.1.10; STAR Health, Att. B-1 § 8.1.10; STAR Kids, Att. B-1 § 8.1.11]

KK. Waiting Times. Provider must provide services within the following timeframes:

1. Emergency Services must be provided upon the Members presentation at the service delivery site;
2. Treatment for Urgent Condition, including urgent specialty care, must be provided within 24 hours;
3. Routine primary care must be provided within 14 days;
4. Initial outpatient behavioral health visits must be provided within 14 days;
5. Community Long-Term Services and Supports for Non-HCBS STAR+PLUS Members must be initiated within 7 days from the date Company authorizes services unless the referring provider or Member state otherwise;

6. PCPs must make referrals for specialty care on a timely basis, based on the urgency of the Member's condition, but no later than 30 days;
7. Pre-natal care must be provided within 14 days, except for high-risk pregnancies or new members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists;
8. Preventative health services for adults must be offered within 90 days; and
9. Preventative health services for children, including well-child check must be offered to CHIP members in accordance with the American Academy of Pediatrics periodicity schedule. For Medicaid Members, well-child check must be offered in accordance with the Texas Health Steps periodicity schedule. For new Members birth through age 20, overdue or upcoming well-child checkups, including Texas Health Steps medical checkups, must be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child members. The Texas Health Steps annual medical checkup for an existing Member age 36 months and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. For purposes of this requirement, the terms "New Member" and "Existing Member" are defined in Chapter 12.4 of the UMCM.

[CHIP, UMCC, Att. B-1, § 8.1.3.1, RSA, Att. B-1 § 8.1.3.1; STAR, UMCC, Att. B-1, § 8.1.3.1; STAR+PLUS, UMCC, Att. B-1, § 8.1.3.1, S+P Ex., Att. B-1 § 8.1.3.1, S+P MRSA, Att. B-1 § 8.1.3.1; STAR Health, Att. B-1 § 8.1.3.1; STAR Kids, Att. B-1 § 8.1.3.1]

LL. Mental Health Providers. If applicable to STAR, STAR+PLUS, STAR Health or STAR Kids Members, Provider must comply with 25 Tex. Admin. Code, Part 1, Chapter 415, Subchapter F, "Interventions in Mental Health Services," when providing Mental Health Reimbursement Services and Mental Health Targeted Case Management. [STAR, UMCC, Att. B-1, § 8.2.7.3; STAR+PLUS, UMCC, Att. B-1, § 8.2.7.3, S+P Ex., Att. B-1 § 8.1.28.2, S+P MRSA, Att. B-1 § 8.1.30.1; STAR Health, Att. B-1 § 8.1.1.7.8; STAR Kids, Att. B-1 § 8.1.30.1]

MM. STAR Health MCO Government Program. To the extent that Company administers and/or arranges for the provision of health care services to Members under a STAR Health MCO Government Program, and Provider is considered a participating provider in such STAR Health MCO Government Program under the terms of the Agreement, then the following terms shall apply:

Providers who are behavioral health providers must:

1. Submit to Company for inclusion into the Health Passport treatment plans and referrals to other providers.
2. Document the outcome measurement scores in the Health Passport.
3. Function as a member of the PCP Team by coordinating with the PCP and Service Manager as appropriate.
4. Testify in court as needed for child protection litigation.

[UMCM, Chapter 8.1, no. 10]

Providers who are behavioral health providers must provide a monthly summary form, to be provided by Company. The following information must be included in the monthly summary form for the Health Passport:

1. Primary and secondary (if present) diagnosis.
2. Assessment information, including results of a mental status exam.
3. Brief narrative summary of the Member's clinical visits/progress.
4. Scores on each outcome rating form(s).
5. Referrals to other providers or community resources.
6. Referrals to providers or community resources.
7. Evaluations of each Member's progress at intake, monthly, and at termination of the Health Care Service Plan, or as significant changes are made in the treatment plan.
8. Any other relevant care information.

[STAR Health, Att. B-1, §§ 8.1.12 & 8.1.17]

Providers who are PCPs must use the Texas Health Steps BH forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders, including possible substance abuse or chemical dependency. The PCP must submit completed Texas Health Steps screening and evaluation results to Company to include in the Health Passport. [STAR Health, Att. B-1, § 8.1.17]

Coordination Between Behavioral Health Services Provider and PCP. Provider must comply with the most recent version of the *Psychotropic Medication Utilization Parameters for Foster Children* found at http://www.dfps.state.tx.us/Child_Protection/medical_Services/guide-psychotropic.asp. [STAR Health, Att. B-1, § 8.1.17.4]

Provider Responsibilities. At the request of HHSC for Texas Department of Family and Protective Services (DFPS), Providers must testify in court as needed for child protection litigation. [STAR Health, Att. B-1, § 8.1.11]

PCPs must:

1. either be enrolled as THSteps providers or refer Members due for a THSteps check-up to a THSteps provider;
2. refer Members for follow-up assessments or interventions clinically indicated as a result of the THSteps check-up, including the developmental and behavioral components of the screening;
3. submit information from the THSteps forms and documents to the Health Passport.

[STAR Health, Att. B-1, § 8.1.4.2]

NN. Dentists.

Main Dentists must:

1. provide children enrolled in CHIP (birth through age 18) with preventive services in accordance with the American Academy of Pediatric Dentistry (AAPD) recommendations, and children enrolled in Medicaid (birth through age 20) with preventive services in accordance with the Texas Health Steps dental periodicity schedule;
2. assess the dental needs of Members for referral to specialty care providers and provide referrals as needed; and
3. coordinate Members' care with specialty care providers after referral.

[STAR Health, Att. B-1, § 8.1.18.2]

To the extent that Company administers and/or arranges for the provision of health care services to Members under a First Dental Home Initiative Government Program, and Provider is considered a participating provider in such Program under the terms of the Agreement, then Provider certifies that he or she has completed the training and registration requirements for Texas Health Steps First Dental Home Initiative providers. [STAR Health, Att. B-1, § 8.1.18.1]

Dental Providers must provide:

1. Urgent care, including urgent specialty care, within 24 hours of a Member's request; and
2. Therapeutic and diagnostic care within 14 days of a Member's request.

In addition, Main Dentists must provide routine preventive care referrals within 30 days of a Member's request. [STAR Health, Att. B-1, § 8.1.3.1]

OO. Medical Consent Requirements. Providers must comply with medical consent requirements in Texas Family Code § 266.004, which require the Member's Medical Consenter to consent to the provision of medical care.

[UMCM, Chapter 8.1, no. 52] Providers must notify the Medical Consenter about the provision of Emergency Services no later than the second Business Day after providing Emergency Services, as required by Texas Family Code § 266.009. [STAR Health, Att. B-1, § 8.1.3]

II. Texas State Regulatory Requirements

The following provisions are required by state law. The definitions found in TIC § 843.002 and 28 TAC § 11.2, as amended, are herein incorporated by this reference.

A. Continuity of Care

The termination of the Agreement, except for reason of medical competence or professional behavior, does not release the obligation of Company to reimburse Provider who is treating a Member of special circumstance, such as a Member who has a disability, acute condition, life threatening illness, is past the twenty-fourth (24th) week of pregnancy, or other condition, at no less than the rates provided for in the Agreement for the Member's care in exchange for continuity of ongoing treatment of a Member receiving Medically Necessary treatment such that Provider reasonably believes that discontinuing care by Provider could cause harm to the patient. Special circumstance shall be identified by Provider who must request that the Member be permitted to continue treatment under Provider's care and agree not to seek payment from the Member of any amounts for which the Member would not be responsible if the Agreement had not terminated. Any dispute between Company and Provider regarding the necessity of continued treatment by Provider shall be resolved in accordance with the process set forth in the Provider Manual. Company will continue to reimburse Provider for treating a Member who has special circumstances until (1) the 90th day after the effective date of the termination; or (2) if the Member has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination; or (3) if a Member is past the 24th week of pregnancy at the time of termination, through delivery of the child and for immediate postpartum care and a follow-up checkup within the six-week period after delivery. TEX. INS. CODE § 843.362, 28 TEX. ADMIN. CODE § 11.901(a)(3).

B. Provider Termination and Notice to Members

At least 90 days before the effective date of the proposed termination of the Agreement, Company must provide a written explanation to Provider of the reasons for termination. Company may immediately terminate the Agreement in a case involving: (1) imminent harm to patient health; (2) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs Provider's ability to practice medicine, dentistry, or another profession; or (3) fraud or malfeasance.

Not later than 30 days following receipt of the termination notice, Provider may request a review of Company's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a license, or fraud or malfeasance. The advisory review panel must be composed of physicians and providers, as those terms are defined in § 843.306 of the Texas Insurance Code, including at least one representative in Provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Company. The decision of the advisory review panel must be considered by Company but is not binding on Company. Within 60 days following receipt of Provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and Company must communicate its decision to Provider. Company must provide Provider, on request, a copy of the recommendation of the advisory review panel and Company's determination.

Reasonable advance notice will be given to a Member of the impending termination from the plan of Provider who is currently treating the Member. If the Agreement is being terminated for reasons related to imminent harm, Company may notify Members immediately. TEX. INS. CODE § 843.306-309; 28 TEX. ADMIN. CODE § 11.901(a)(3).

C. Member Grievance Dispute Resolution

The Section of the Agreement titled "Member Grievance Dispute Resolution" shall be deleted in its entirety and replaced with the following:

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 the Agreement. As required by state law, Provider shall post a notice to Members on the process for resolving complaints with Company including the Department of Insurance toll-free telephone number for filing complaints. TEX. INS. CODE § 843.283; 28 TEX. ADMIN. CODE § 11.901(a)(6). Company shall not terminate or refuse to renew the Agreement or otherwise retaliate against Provider because Provider reasonably filed a complaint or an appeal on behalf of a Member. TEX. INS. CODE § 843.281; 28 TEX. ADMIN. CODE § 11.901(a)(2).

D. Electronic Claims Submission

In the event of a systems failure, or a catastrophic event that substantially interferes with the business operations of the physician or Provider, Provider may submit non-electronic claims for the number of calendar days during which substantial interference with business operations occurs as of the date of the catastrophic event or systems failure. Provider shall provide written notice of Provider's intent to submit non-electronic claims to Company within five calendar days of the catastrophic event or systems failure. TEX. INS. CODE § 1213.002; 20 TEX. ADMIN. CODE §§11.901(a)(13); 21.3701.

Provider may submit a request for a waiver of the electronic submission requirements of the Agreement in any of the following circumstances:

1. No method available for the submission of claims in electronic form. This exception applies to situations in which the federal standards for electronic submissions (45 C.F.R., Parts 160 and 162) do not support all of the information necessary to process the claim.

2. The operation of small physician and provider practices. This exception applies to those physicians and Providers with fewer than ten full-time-equivalent employees, consistent with 42 C.F.R. § 424.32(d)(1)(viii).

3. Demonstrable undue hardship, including fiscal or operational hardship.

4. Any other special circumstances that would justify a waiver.

Provider's request for a waiver must be in writing and must include documentation supporting the issuance of a waiver. TEX. INS. CODE § 1213.003, 28 TEX. ADMIN. CODE §§ 21.3701; 11.901(13).

E. Overpayments

Provider agrees that Company may recover a refund due to an overpayment or completion of an audit if Company notifies Provider in writing not later than one hundred and eighty (180) days after the overpayment or completion of the audit. If Provider has not made arrangements to repay or otherwise appeal Company's notice within forty-five (45) days of Company's notice of overpayment or within thirty (30) days of notice of completion of audit, Company will offset the amount of the overpayment against future payments owing to Provider for any reason. If Provider disagrees with Company's request for recovery of overpayment or refund, Provider may appeal the request in writing as provided for in Company's notice of its intent to recover the overpayment.

F. Coordination of Benefits

Provider agrees to collect and maintain primary payor information in the Member's medical or billing records and to provide such information to Company so that Company can coordinate benefits according to the Member's health benefits and the Agreement.

G. Expedited Credentialing

If Physician joins an established medical group that has a current contract in force with Company, Company will expedite credentialing of Physician for the limited purposes set out below, provided Physician:

1. is licensed in Texas by, and in good standing with, the Texas Medical Board;
2. submits all documentation and other information required by Company as necessary to enable Company to begin the credentialing process to include Physician in the issuer's health benefit plan network; and
3. agrees to comply with the terms of Company's Participating Provider contract currently in force with the applicant Physician's established medical group.

On submission by Physician of the information above, Company will treat the applicant Physician as if the Physician were a participating provider in the health benefit plan network for payment purposes only when the applicant Physician provides services to Members, including:

1. authorizing the applicant Physician to collect copayments, if any, from the Members; and
2. making payments to the applicant Physician.

If, on completion of the credentialing process, Company determines that the applicant Physician does not meet Company's credentialing requirements:

1. Company may recover from the applicant Physician or the Physician's medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and
2. applicant Physician or the Physician's medical group may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

A Member is not responsible and shall be held harmless for the difference between in-network copayments paid by the Member to a Physician who is determined to be ineligible and Company's charges for out-of-network services. Physician and the Physician's medical group may not charge the enrollee for any portion of the Physician's fee that is not paid or reimbursed by Company.

Individual Sites Regulatory Addendum – Exhibit A
New Jersey Medicaid Regulatory Compliance Addendum – Provider

This New Jersey Medicaid Regulatory Compliance Addendum, including the Attachment 1, MacBride Principles Certification Form, ("Addendum") is incorporated by reference into the Agreement. If there is any conflict between the terms of this Addendum and any other term of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, if there is any conflict between the terms of the Agreement, including this Addendum, and the State Contract, as amended, then the terms of the State Contract will govern and control.

For purposes of this Addendum, the term "Provider" shall mean the party executing the Agreement, as identified on the first page of the Agreement, which may be a health care physician, provider, group, facility, hospital, individual, entity or a delegated entity. For purposes of this Addendum and the State Contract, the term "Contractor" and shall mean Company.

Notwithstanding any other provision of the Agreement, for purposes of this Addendum, "State Contract" means only the State of New Jersey Department of Human Services ("DHS"), Division of Medical Assistance and Health Services ("DMAHS") and Aetna Better Health Inc. Contract to Provide Services, entered into November 17, 2014, and as amended from time to time. "Department" refers to either DMAHS or the New Jersey Department of Banking and Insurance ("DOBI"), as applicable.

Capitalized terms not otherwise defined in the Agreement, or its attachments, shall have the meaning ascribed to them in the State Contract or under applicable law.

1. DMAHS Mandatory Terms

Provider agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions, to the extent applicable to the services provided under the Agreement:

A. SUBJECTION OF AGREEMENT

The Agreement shall be subject to the applicable material terms and conditions of the State Contract between the Company and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Company.

MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Company's provider network requirements shall be included in Company's provider network to serve MLTSS Members. In addition, if Company wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. Company must accept all NFs, SCNF, ALs, CRSs that serve residents with traumatic brain injury, and long term care

pharmacies which are Medicaid providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be for a two year period from the date that the service comes into MLTSS, dependent upon available appropriation in each Fiscal Year. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2016. Thereafter, Company may determine the continuing provider network status of these provider types based on Member utilization and access needs. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation and (b) the negotiated rate between the Company and the facility. This does not preclude volume-based rate negotiations and agreement between the Company and these providers.

2. The Any Willing Plan status also expires June 30, 2016.

3. Long term care pharmacy status as an Any Willing Provider shall not expire. Company shall pay long term care pharmacies the rate negotiated between the Company and the pharmacy.

Claims payment for services to MLTSS Members. Company shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS providers, adult/pediatric medical day care providers, PCA and participant directed Vendor Fiscal/Employer Agent Financial management Services (VF/EA FMS) claims within the following timeframes:

1. HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;

2. Manually submitted clean claims shall be processed within thirty (30) calendar days of receipt.

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

Provider agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and state laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

1. Provider shall submit claims within 180 calendar days from the date of service.

2. Provider shall submit corrected claims within 365 days from the date of service.

3. Provider shall submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

C. APPROVAL OF AGREEMENT AND AMENDMENTS

Provider understands that the State reserves the right in its sole discretion to review and approve or disapprove the Agreement and any amendments thereto.

If applicable and required, Company and any AWP provider shall only amend the Agreement unilaterally for statutory and regulatory changes, and upon mutual consent of the Parties with State approval.

D. EFFECTIVE DATE

The Agreement shall become effective only when the State Contract takes effect.

E. NON-RENEWAL/TERMINATION OF AGREEMENT

Provider understands that the Company shall notify DMAHS at least 45 days prior to the effective date of the suspension, termination, or voluntary withdrawal of Provider from participation in Company's network. If the termination was "for cause," Company's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless Company can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers. [State Contract Section 4.9.3 B]

F. ENROLLEE-PROVIDER COMMUNICATIONS

1. Company shall not prohibit or restrict Provider from engaging in medical communications with Provider's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between Provider and Provider's patient. Providers shall be free to communicate freely with their patients about the health status of their patients, medical care, or treatment options regardless of whether benefits for that care or treatment are provided under the Agreement, if the professional is acting within the lawful scope of practice. Providers shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in Section F.1 shall be construed:

   a. To prohibit the enforcement, including termination, as part of a subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by Company to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider, but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers and their patients; or

   b. To permit a health care provider to misrepresent the scope of benefits covered under the Agreement or to otherwise require Company to reimburse providers for benefits not covered.

G. RESTRICTION ON TERMINATION OF AGREEMENT BY COMPANY

Termination of AWP Providers is limited to State ordered termination as indicated in Section H below. Company shall not terminate the Agreement for either of the following reasons:

1. Because Provider expresses disagreement with Company's decision to deny or limit benefits to a covered person or because Provider assists the covered person to seek reconsideration of the Company's decision; or because Provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by Company or not, policy provisions of Company, or Provider's personal recommendation regarding selection of a health plan based on Provider's personal knowledge of the health needs of such patients.

2. Because Provider engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because Provider practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. TERMINATION OF AGREEMENT – STATE

Provider understands and agrees that the State may order the termination of the Agreement if it is determined that Provider:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;

2. Takes any action that threatens the fiscal integrity of the Medicaid program;

3. Has its certification suspended or revoked by DOBI, DOH, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

4. Becomes insolvent or falls below minimum net worth requirements;

5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;

6. Materially breaches the Agreement; or

7. Violates state or federal law, including laws involving fraud, waste, and abuse.

I. NON-DISCRIMINATION

Provider shall comply with the following requirements regarding nondiscrimination:

1. Provider shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. Provider shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, Provider shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are "qualified individuals with a disability" covered by the provisions of the ADA. Company shall supply a copy of its ADA compliance plan to Provider.

   A "qualified individual with a disability" as defined pursuant to 42 U.S.C.§12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

   Provider shall submit to Company a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that Provider meets ADA requirements to the best of Provider's knowledge. Provider warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of Provider to be in compliance with the ADA. Where applicable, Provider must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. Provider shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to Provider on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4. Provider shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1 through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. Provider shall not discriminate against any employee engaged in the work required to produce the services covered by this Provider contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This nondiscrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.

6. Grievances. Provider agrees to forward to Company copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by Provider.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF THE COMPANY'S INSOLVENCY AND TO HOLD ENROLLEES AND FORMER ENROLLEES HARMLESS

1. Provider shall remain obligated to provide all services for the duration of the period after Company's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

2. Provider agrees that under no circumstances, (including, but not limited to, nonpayment by Company or the state, insolvency of Company, or breach of agreement) will Provider bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in Section 1.P below.

3. Provider agrees that this provision shall survive the termination of the Agreement regardless of the reason for termination, including insolvency of Company, and shall be construed to be for the benefit of Company or enrollees.

4. Provider agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.

5. Provider agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.

6. Provider shall comply with the prohibition against billing members contained in 42 CFR 438.106, N.J.S.A. 30:4D-6.c, and N.J.A.C. 10:74-8.7.

K. INSPECTION

1. Provider shall allow the New Jersey Department of Human Services (DHS), the U.S. Department of Health and Human Services (DHHS), and other authorized State agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the Agreement, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by Provider pertaining to such services, at any time during normal business hours (and after business hours when deemed necessary by DHS or DHHS, or MFD) at a New Jersey site designated by the State. Inspections may be unannounced for cause.

2. Provider shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by Provider, prior to approval of their use for providing services to enrollees.

3. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under the Agreement, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to enrollees. Upon request, at any time during the period of the Agreement, Provider shall furnish any such record, or copy thereof, to the Department or the Department's External Review Organization within 30 days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.

4. The DMAHS, the MFD, or its designee, and the MFCU, shall have the right to inspect, evaluate, and audit all of the following documents in whatever form they are kept, related to the Agreement:

    a. Financial records, including but not limited to tax returns, invoices, inventories, delivery receipts, Medicaid claims;

    b. Medical records, including but not limited to medical charts, prescriptions, x-rays, treatment plans, medical administration records, records of the provision of activities of daily living, ambulance call reports;

    c. Administrative documents, including but not limited to credentialing files, appointment books, prescription log books, correspondence of any kind with Company, DMAHS, CMS, any other managed care contractor, Medicaid recipient, contracts with subcontractors, and contracts with billing service providers; and

    d. All records required to be kept to fully disclose the extent of services provided to Medicaid recipients, pursuant to NJAC 10:49-9.8(b) (1).

L. RECORD MAINTENANCE

Provider shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. RECORD RETENTION

Provider hereby agrees to maintain an appropriate recordkeeping system for services to enrollees. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary and make that information readily available to appropriate health professionals and the Department. Records must be retained for the later of:

1. Five (5) years from the date of service, or

2. Three (3) years after final payment is made under the Agreement and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the Company, Provider shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 1.R., Confidentiality, and at no cost to the enrollee.

N. DATA REPORTING

Provider agrees to provide all necessary information to enable Company to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. DISCLOSURE

1. Provider further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of Company's agreement with the State.

2. Provider shall comply with financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.

3. Provider shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106 and complete a disclosure statement, which will be maintained by Company.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

Provider shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A and B enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with applicable law. Any such contributions shall be set forth in an attached schedule.

Q. INDEMNIFICATION BY PROVIDER

1. Provider agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of the Agreement.

2. Provider agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of the Agreement.

3. Provider agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which Provider receives payment.

4. Provider agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under the Agreement, or for any libelous or otherwise unlawful matter contained in such data that Provider inserts.

5. Provider shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of Provider, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. Provider shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by Provider.

R. CONFIDENTIALITY

1. General. Provider hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of Provider and Company and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.4. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of the Agreement including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by Company's Plan that are eligible through the Division of Youth and Family Services, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by Provider, it: (a) shall not use any such information for any purpose other than carrying out the express terms of the Agreement; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c)

shall not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than the Department without the Department's prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the Agreement, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. Provider shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within Provider's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of the Agreement.

5. The provisions of this Section R shall survive the termination of the Agreement and shall bind Provider so long as Provider maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, Provider is responsible for complying, at a minimum, with the following statues and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U.S.C. 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. CLINICAL LABORATORY IMPROVEMENT

Provider shall ensure that all laboratory testing sites providing services under the Agreement have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. FRAUD, WASTE, AND ABUSE

1. Provider agrees to assist Company as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.

2. If the State has withheld payment and/or initiated a recovery action against Provider, or withheld payments pursuant to 42 CFR 455.23 and NJAC 10:49-9.10(a), Company shall have the right to withhold payments from Provider and/or forward those payments to the State.

3. Company and its providers, and subcontractors, whether or not they are enrolled Medicaid providers, shall cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DOH, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. Company shall include language in its contracts with its providers and subcontractors, requiring cooperation, and stating that a failure to cooperate shall be grounds for termination of Company's Agreement with provider or subcontractor. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

4. MFD shall have the right to recover directly from providers and enrollees in the Company's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with Company, but reported to DMAHS in the format that the Company reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the Company to withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by Company shall be sent to MFD from Company and reported to DMAHS in the format that Company reports its recoveries to DMAHS.

5. Company shall have the right to recover directly from providers, subcontractors and enrollees in Company's network for the audits and investigations the Company solely conducts.

U. THIRD PARTY LIABILITY

1. Provider shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.

2. Except as provided in subsection 3. below, if Provider is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to Company.

3. In the following situations, Provider may bill Company first and then coordinate with the liable third party, unless Company has received prior approval from the State to take other action.

   a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.
   b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.
   c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.
   d. The claim is for a child who is in a DCP&P supported out of home placement.
   e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.

4. If Provider knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, Provider may bill Company without having received a written denial from the third party.

5. Sharing of Third Party Liability (TPL) Information by the Provider/Subcontractor.

   a. Provider shall notify the Company within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by Company, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.

   b. When Provider becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, Provider shall notify Company in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in Provider's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee's diagnosis and the nature of the service provided to the enrollee.

   c. Provider shall notify Company on no less than a weekly basis when it becomes aware of the death of one of its Medicaid enrollees age 55 or older, utilizing the "Combined Notification of Death and Estate Referral Form" located in subsection B.5.1 of the Appendix of the State Contract, as it may be amended from time to time.

   d. Provider agrees to cooperate with Company's and the State's efforts to maximize the collection of third party payments by providing to Company updates to the information required by this Section.

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's or subcontractor's sole recourse for payment, other than collection of any authorized cost-

sharing, patient payment liability and /or third party liability, is Company, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i), 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section and/or NJAC 10:74-9.1 and 4.2.1D.2 of the contract), or NJAC 10:74-9.1; and

d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and

e. The protections afforded to enrollees under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

f. The provider has received no program payments from either DMAHS or Company for the service; or

g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in Company's network; or

b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

2. Miscellaneous DMAHS Terms Required by Law or State Contract

A. DEFINITIONS

1. The definition of "Clean Claim" in the Agreement is stricken and replaced with:

"A claim by Provider where 1) the claim is for a service or supply covered by the Member's Plan; 2) the claim is submitted with all the information requested by Company or in other instructions; 3) the person to whom the service or supply was provided was a Member on the date of service; 4) Company does not reasonably believe that the claim has been submitted fraudulently; and 5) the claim does not require special treatment. For the purposes of this definition, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. In order to accept a claim, the information requested by Company is specified in its Policies, which

include the requirements that a claim have (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, and (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-9, 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). Further information on the type of information and documentation that must be submitted with a claim, including a standard claim form and any other claim submission requirements utilized by the carrier for both manually and electronically submitted claims, and a street address where claim submissions can be delivered by hand or registered/certified mail, is available in Company's Policies and/or its website."

2. The following is added to the end of the definition of Emergency Medical Condition: "With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child."

B. INSURANCE. 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 of $1,000,000 per claim/$3,000,000 annual aggregate as required by State law.

C. COOPERATION. Provider must cooperate and participate in Company's quality management and utilization management system, including credentialing/recredentialing; appointment standards; and enrollee and provider complaint and grievance system.

D. EQUALITY OF ACCESS. To the extent applicable, Provider shall provide the same level of medical care and health service to DMAHS enrollees as it does to enrollees under private or group contracts.

E. MONITORING.

1. Monitoring by Company. The responsibilities performed by Provider are monitored on an ongoing basis and Company is ultimately responsible to the HHS for the performance of all services. Company is responsible for ensuring that the performance of Providers is consistent with the State Contract. Company has the right to revoke the Agreement if Provider does not perform satisfactorily, subject to the termination provisions herein.

2. Monitoring/Enforcement by State. The Department may require Company to terminate the Agreement if performance is not consistent with the State Contract.

F. SEVERABILITY. Any determination that any provision of the 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 the Agreement. Neither Party shall assert or claim that the Agreement or any provision hereof is void or voidable if such part performs under the Agreement without prompt and timely written objection.

G. MACBRIDE PRINCIPLES CERTIFICATION FORM. Provider must execute the MacBride Principles Certification Form included in Attachment 1.

H. PAYMENT OF CLAIMS AND COMPENSATION

1. DMAHS Recoveries. Whenever DMAHS has initiated a recovery claim against Provider, whether that recovery claim arises out of Provider's fee-for-service or managed care participation, Company must comply with any

written request from DMAHS to withhold all or part of any payments that are owed by the Company to Provider up to the amount of DMAHS's recovery claim, and Company must immediately remit those payments to DMAHS. Provider and any subcontractor of Provider shall fully cooperate with Company in Company's compliance with these procedures. [State Contract Section 8.12]

2. Encounter Data. Provider agrees to cooperate in the implementation of Company's Encounter Data submission incentive system. Such system, set forth in Company's Policies, includes mandatory provider profiling that includes complete and timely submissions of encounter data, as well as specific requirements for profile elements based on data from encounter submissions. Compliance performance with Company's data submission requirements based on encounter data elements will be both rewarded and/or sanctioned in accordance with the Policy.

3. Financial Risk. Unless expressly set forth elsewhere in the Agreement, Provider is not subject to financial risk for the delivery of Covered Services by persons or entities other than Provider. Provider either a) certifies that no such financial risk is imposed by Provider upon other persons or entities (such as subcontractors or employed physicians); or if such risk is imposed, b) will promptly disclose such to Company and cooperate to fulfill Company's obligations of disclosure to Government Sponsor, and fulfill all other requirements of applicable law and the State Contract.

4. No Prohibited Incentives. No compensation is payable under the Agreement as a financial incentive to Provider for the withholding of Covered Services that are Medically Necessary.

5. Time for Submission of Claims. Notwithstanding the time periods stated in Section 4.1.1 of the Agreement, Provider agrees that Company, or the applicable Government Sponsor, will not be obligated to make payments for billings received more than one hundred and eighty (180) days 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 make payment for billings received outside of such time period, upon consideration of the factors set forth in N.J.A.C. 11:22-3.4(e), when addressed by Provider.

I. INFORMATION AND RECORDS

Without limitation, the government agencies permitted access to Information under Section 5.3.2 of the Agreement include the New Jersey Departments of Banking and Insurance, Health and Senior Services and Human Services. In addition to the purposes stated in Section 5.3.2, such regulators may access Information for the purpose of assessing the quality of care or investigating Member grievances or complaints.

J. TERMINATION OF PROVIDER

1. Prohibited Terminations. Company shall not terminate the Agreement because Provider expresses disagreement with Company's decision to deny or limit benefits to a Member or because Provider assists the Member to seek reconsideration of the Company's decision, or because Provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by Company or not, policy provisions of a plan, or Provider's personal recommendation regarding selection of a health plan based on the Provider's personal knowledge of the health needs of such patients. Nor shall Company terminate the Agreement or penalize Provider because (a) Provider filed a complaint or appeal as permitted by the New Jersey regulations governing health maintenance organizations, or (b) for acting as an advocate for the Member for seeking benefits for appropriate, medically necessary health services. [NJA 11:24-15.2 (b) 2, (b) 3]. Nevertheless, Provider is prohibited from making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature that is false or maliciously critical of Company and calculated to injure Company. A material misrepresentation by Provider of the provisions, terms, or requirements of Company shall be a breach of the Agreement for which Company may exercise its rights of

termination. [State Contract Section 4.9.3.D.]

2. Government Sponsor Termination. In addition to those grounds for termination set forth in Section 6.4 of the Agreement or elsewhere, Company may terminate the Agreement immediately upon direction from Government Sponsor if Provider's performance is not consistent with the State Contract.

3. Additional Terms for Transition. The Parties agree that, regardless of which party terminates the Agreement, the Parties shall abide by the terms of the Agreement, including the compensation terms, for four (4) months following the date of termination for cases in which it is medically necessary for a Member to continue treatment with the terminated Provider, except a longer period shall apply in the following cases: i) for Members who are pregnant at the termination date, the Agreement shall continue through the post-partum evaluation of the Member, up to six (6) weeks after delivery; ii) for Members who are in post-operative care at the termination date, the Agreement shall continue for a period of up to six (6) months; iii) for Members who are receiving oncologic treatment at the termination date, the Agreement shall continue for a period of up to one (1) year; iv) for Members who are receiving psychiatric treatment at the termination date, the Agreement shall continue for up to one (1) year; v) to any Member who is an inpatient at Provider 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 vii) at Company's request to any Member for up to one (1) calendar. Notwithstanding the foregoing, i) the Agreement shall not continue in force hereunder if the Provider has been terminated based upon the opinion of Company's Medical Director that the Provider is an imminent danger to a patient, public health, safety and welfare, a determination of fraud, breach of contract, termination in accordance with Section 6.4 of the Agreement (or section 2 above) or if the Provider is the subject of disciplinary action by the State Board of Medical Examiners. [NJAC 11:24-3.5]

3. New Jersey Department of Banking and Insurance (DOBI) Required Terms.

The following terms and conditions apply only to the Agreement if it relates to the provision of health care services or supplies by Provider. Provider agrees that all contracts it has with providers or subcontractors in accordance with the terms of the Agreement shall specifically refer to and contain all of the provisions set forth in NJAC 11:24-15 and require that its providers and subcontractors comply with all of the terms and conditions set forth therein.

A. Licensure/Certification. Provider shall maintain appropriate licensure and certifications required in order to perform its obligations under the Agreement and adequate malpractice coverage.

B. No Violation of Law. The Agreement shall not be interpreted to impose obligations or responsibilities upon Provider which require Provider to violate the statutes or rules governing licensure of Provider if Provider is to comply with the terms of the Agreement. [NJAC 11:24-15, 4(e).

C. Notice of Termination. If the Agreement between Company and Provider is terminated by Company on any date other than the designated renewal or anniversary date, Company shall give Provider at least ninety (90) days prior written notice of the termination and the opportunity to request a hearing in all instances except when the termination is based upon non-renewal of the Agreement, a determination of fraud, breach of contract by Provider, sanctions by a state or federal agency, or the opinion of Company's medical director that Provider represents an imminent danger to a Member or the public health, safety and welfare. The notice of termination shall specify: (a) that the Provider may request in writing from Company, within fifteen (15) days of receipt of the notice, a written reason for the termination unless such reason is already stated in the notice, (b) that the Provider may request a hearing, and; (c) the procedures for exercising Provider's right to a hearing. Provider's participation in the hearing process shall not be deemed an abrogation of Provider's legal rights.

D. Pricing Following Termination. To the extent applicable, Provider shall continue to provide services to members at the Agreement price following termination of the Agreement, in accordance with NJAC. 11:24-3.5.

E. DISPUTE RESOLUTION

1. Hearing Upon Termination. Hearings for Agreement termination, when permitted under the Agreement, shall be

conducted in accordance with the following guidelines: (a) Provider shall have the right to make a written request for a hearing within ten (10) business days following the date of receipt of notice of termination; (b) the Agreement shall be deemed to have terminated, creating the right to a hearing, whenever Agreement terminates on any date other than a designated renewal or anniversary date of the Agreement, except that no such right shall exist with respect to termination described in Section 6.4.1 of the Agreement; (c) if no renewal of anniversary date is specified in the Agreement, then the renewal or anniversary date shall be deemed to be the month and day in each calendar year on which the Agreement was originally signed by both Parties, or became effective, whichever date is latest; (d) Company shall hold a hearing before a panel appointed by the Company, within thirty (30) days following receipt of a written request for a hearing by Provider; (e) the panel shall consist of no less than three (3) people, at least one of whom shall be a clinical peer in the same or substantially similar discipline and specialty as the Provider requesting the hearing; (f) Company shall not preclude Provider from being present at the hearing or represented by counsel at the hearing; (g) the panel shall render a decision on the matter within thirty (30) days of the close of the hearing unless the panel provides notice to Company and Provider of the need for an extension for rendering its decision, prior to the date that the decision would otherwise be due; (h) the panel's decision shall set forth the relevant Agreement provisions and the facts upon which the Company and Provider have relied at the hearing; (i) the panel shall recommend that the Provider be terminated, reinstated or provisionally reinstated, and specify the reasons for its recommendations, including the reasons for any provisional reinstatement; (j) with regard to provisional reinstatements, the panel shall specify the conditions for provisional reinstatement, the duration of the conditions, and the consequences of the failure to meet the conditions; (k) in the event of reinstatement or provisional reinstatement, the panel shall specify the impact of the reinstatement upon the terms of duration of the Agreement at issue; (l) in the event that the panel recommends that Provider be terminated, Company shall provide notice of termination to Members in accordance with New Jersey law and Provider shall continue to provide services to Members at the contract price following termination, in accordance with New Jersey law pertaining to continuity of care; and (m) Provider's participation in the hearing shall not be deemed to be an abrogation of Provider's legal rights. NJAC 11:24-3.6.

2. Provider Disputes. Company's internal provider grievance dispute resolution mechanism described in the Agreement will be more fully described in Company's Policies. Where required under applicable law, the dispute resolution procedure will provide for appeal before an Independent Utilization Review Organization or Medicaid Fair Hearing. Matters determined by these bodies are conclusive upon the Parties and not subject to further appeal, arbitration or litigation between the Parties (unless otherwise provided for under state and federal law).

F. AMENDMENTS

Any amendment to the Agreement may require the prior approval of the New Jersey Department of Banking and Insurance. Provider understands that the State reserves the right in its sole discretion to review and approve or disapprove the Agreement and any amendments thereto.

G. SECONDARY CONTRACTORS

To the extent Provider is or acts as a secondary contractor (as defined in Section 11:24-1.2 of the New Jersey Administrative Code), Company is a third party beneficiary of the secondary contractor's contract(s) with the health care providers, and Provider's contract(s) with health care providers shall provide that Company shall have privity of contract with the health care providers such that the Company shall have standing to enforce Provider's contract(s) with the health care providers in the absence of enforcement by Provider. [NJAC 11:24-15.2(f)]. All Provider's agreements with health care providers shall be consistent with laws regarding confidentiality of information and with professional licensing standards, including, but not limited to, New Jersey Statutes Sections 45:14B-31 et seq. and 11:24-15.2(b-e) of the New Jersey Administrative Code. Such contracts shall include a provision whereby the provider is required to hold Members harmless for the cost of any service or supply covered by Company, subject to Section 11:24-15.2(b)(7)(i & ii), whether or not the provider believes the compensation received is adequate. Secondary contractors shall maintain throughout the term of the Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies. Company reserves the right to enter into separate contracts directly with such health care providers, as set out in NJAC 11:24-15.2(g).

Notwithstanding the foregoing sentence, the rights of Company as a third party beneficiary and of privity of contract with respect to Provider's contracts with heath care providers in no way limit Provider's obligations to enforce the terms of such contracts nor shall such rights be construed in any way to impose an obligation on Company to enforce such contracts.

4. Mandatory Requirements for Particular Provider Types

The following terms are incorporated into the Agreement only as applicable to Provider's specific provider type.

A. FEDERALLY QUALIFIED HEALTH CENTERS [State Contract Section 4.9.2.A]

1. Provider will deliver the following specific services under the terms of the Agreement:

   [List services if applicable]

2. The credentialing requirements for individual practitioners are set forth in Company's Policies.

3. Continuation of the Agreement is contingent on Provider maintaining quality services and maintaining the Primary Care Evaluation Review (PCER) by the federal government at a good quality level. Provider must make available to Company its PCER results annually, which will be considered in the Provider's QM reviews for assessing quality of care.

B. HOSPITALS

1. Provider will deliver the following specific services under the terms of the Agreement:

   [List services if applicable]

2. Company shall pay for all medical screening services rendered to Members by hospitals and emergency room physicians. The amount and method of reimbursement for medical screenings for Hospital is set forth in the Agreement, or in a separate agreement with non-hospital-salaried emergency room physicians. Such reimbursement includes reimbursement for urgent care and non-urgent care rates.

3. Prior authorization for medical screenings, emergency care, or urgent care situations at the hospital emergency room is not be required. The hospital emergency room physician may determine the necessity for contacting the PCP or the Company for information about a patient who presents with an urgent condition. Provider must notify Company of a hospital admission through the emergency room within 24 to 72 hours of the admission, and notify Company of all Members who present in the emergency room for non-emergent care who have been medically screened but not admitted as an inpatient within 24 to 72 hours of the rendered service.

C. PRIMARY CARE PHYSICIANS [State Contract Section 4.8.2]

In addition to those responsibilities of a PCP set forth in the agreement, all Providers who are PCP's shall:

1. Supervise, coordinate, and manage Members' care;
2. Maintain Members' medical records;
3. Provide 24 hour/7 day a week access; and
4. Make referrals for specialty care.

D. NURSING AND REHABILITATION FACILITIES

Provider must contact Company prior to or within 24 hours of admission of a Member for authorization of care. [State Contract Section 4.9.2.A]

E. ALL FACILITIES

Provider must follow clear procedures for granting of admitting and attending privileges to physicians, and notify Company when such procedures are no longer appropriate. The admission authorization procedures for Members; the procedures for notifying Company when Members present at emergency rooms and the procedures for billing and payment, schedules, and negotiated arrangements, if not set forth herein, are contained in Company's Policies.

ATTACHMENT 1
MACBRIDE PRINCIPLES CERTIFICATION FORM

COMPLETE THIS CERTIFICATION IN COMPLIANCE WITH MACBRIDE PRINCIPLES AND NORTHERN IRELAND ACT OF 1989

Pursuant to Public Law 1995, c.134, Provider must complete the certification below by checking one of the two representations listed and signing where indicated.

I certify, pursuant to N.J.S.A. 52:34-12.2 that the entity for which I am authorized to contract:

____ has no ongoing business activities in Northern Ireland and does not maintain a physical presence therein through the operation of offices, plants, factories, or similar facilities, either directly or indirectly, through intermediaries, subsidiaries or affiliated companies over which it maintains effective control; or

____ will take lawful steps in good faith to conduct any business operations it has in Northern Ireland in accordance with the MacBride principles of nondiscrimination in employment as set forth in N.J.S.A. 52:18A-89.5 and in conformance with the United Kingdom's Fair Employment (Northern Ireland) Act of 1989, and permit independent monitoring of their compliance with those principles.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature:

Date:

Print Name:

Title:

Firm Name:

Individual Sites Regulatory Addendum – Exhibit A

VIRGINIA MEDICAID REGULATORY COMPLIANCE ADDENDUM – PROVIDER

This Medicaid Compliance Addendum is incorporated by reference in the Agreement. If there is any conflict between the terms of this Addendum and any of the terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, that if there is any conflict between any of the terms of the Agreement, including this Addendum, and the applicable State Contract, then the terms of the applicable State Contract will govern and control.

For purposes of this Addendum, the term "Provider" shall mean the health care provider, or physician, group, facility or hospital executing the Agreement, as identified on the first page of the Agreement. In the event that any of the following required Medicaid provisions are inapplicable to Provider, as construed under the applicable State Contract and in accordance with Applicable Law, such provision shall not apply.

Company and Provider agree to abide by all applicable provisions of the applicable State Contract. Provider compliance with the applicable State Contract specifically includes, but is not limited to, the requirements contained herein.

1.0 DEFINITIONS

All capitalized terms in this Addendum shall have the meaning set forth in the Agreement unless otherwise defined herein, in which case the definitions contained in this Addendum shall control.

1.1 Applicable Law. All federal or state laws, rules, regulations, and administrative agency directives applicable to the Medicaid program and to Medicaid managed care plans, as these may be amended from time to time, including, but not limited to, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kickbacks. Applicable Laws include the Centers for Medicare and Medicaid Services ("CMS") and the Virginia Department of Medical Assistance Services' ("DMAS" or the "Department") instructions, policy letters or guidelines that regulate the actions of Provider or Company, requirements of the State Plan, as applicable, and requirements of the applicable State Contract. The "State Plan" is the State Plan for Medical Assistance, submitted to CMS by DMAS describing the nature and scope of the Virginia Medicaid program. DMAS has the authority to administer the State Plan under Code of Virginia § 32.1-325. The words "applicable law," as they appear in the Agreement, shall have the same meaning as given to "Applicable Law" herein.

1.2 Medically Necessary or Medical Necessity. Appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 CFR § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. For children under age 21, medical necessity review must fully consider Federal EPSDT guidelines for Medallion 3.0 enrollees. EPSDT is not applicable to FAMIS. (*Medallion 3.0 Contract, Section 1.1; FAMIS Contract, Section 1.1)*

2.0 REGULATORY AND CONTRACTUAL REQUIREMENTS FOR MEDALLION 3.0 AND FAMIS

2.1 Duty to Refund. Provider shall be required to refund payments made by DMAS if Provider is found to have billed DMAS contrary to policy, failed to maintain records or adequate documentation to support its claims, or billed for medically unnecessary services. (*12VAC30-120-1720(A)(4); 12VAC30-141-650(D); and 12VAC30-141-870(D)*)

2.2 Provider Agreement Subject to Department Review. Provider acknowledges and agrees that the Department may approve, modify and approve, or deny the Agreement and any changes in approved agreements at its sole discretion. Provider further acknowledges and agrees that the Department, at its sole discretion, may impose such conditions or limitations on its approval of the Agreement or changes to approved agreements as it deems appropriate. Provider shall cooperate with Company in Company's submission to the Department of the Agreement for initial approval and, if necessary, approval of any future changes. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III*)

2.3 Validity of Terms. No terms of the Agreement are valid which terminate legal liability of Company in the applicable State Contract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.1*)

2.4 Provider Cooperation with Company Programs. Provider agrees to participate in and contribute required data to Company's quality improvement and other assurance programs as required in the applicable State Contract. Provider agrees to cooperate with the External Quality Review Organization (EQRO), which is contracted by the Department to perform quality studies. The level of cooperation includes, but is not limited to, responding favorably and promptly to requests for Members' medical records in the format and timeframe requested by the EQRO or the Department. (*Medallion 3.0 Contract, Section 8.4 and Attachment III; FAMIS Contract, Section 8.4 and Attachment III, Section A.2*)

2.5 Emergency and Urgent Care. Provider agrees to abide by the terms of the applicable State Contract for the timely provision of emergency and urgent care. Where applicable, Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by Company in accordance with the applicable State Contract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.3*)

2.6 Utilization Data. Provider agrees to submit to Company utilization data in the format specified by Company, so Company can meet the Department specifications required by the applicable State Contract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.4*)

2.7 Conflicts. Any conflict in the interpretation of Company's Policies and MCO-Network Provider contract shall be resolved in accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices and provider manuals. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.5*)

2.8 Non-discrimination. Provider agrees to comply with all non-discrimination requirements in the applicable State Contract. For example, but not by way of limitation, Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if Provider serves only Medicaid members. (*Medallion 3.0 Contract, Section 3.9 and Attachment III; FAMIS Contract, Section 3.9 and Attachment III, Section A.6*)

2.9 Record Retention. Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in the applicable State Contract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.7*)

2.10 Maintenance of Records. Provider agrees to comply with the requirements for maintenance and transfer of medical records stipulated in the applicable State Contract and all Applicable Laws. (*12VAC5-408-210(A) and (B); Medallion 3.0 Contract, Section 14.19; FAMIS Contract, Section 14.19; FAMIS Regulations, 12VAC30-141-650(B) and 12VAC30-141-870(B)*)

2.11 Access to Facilities and Records.

2.11.1 Provider agrees to provide representatives of Company, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Fraud Unit access to its premises and its books, fee schedules, documents, papers, records, contracts and/or medical records in accordance with the applicable State Contract. Provider must allow the Department, or its duly authorized representatives to inspect, copy, and audit any of Provider's medical and/or financial records. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with the applicable State Contract. Provider must forward to Company medical records within ten (10) working days of Company's request. (*Medallion 3.0 Contract, Section 14.19.B.1 and Attachment III; FAMIS Contract, Section 14.19.B.1 and Attachment III, Section A.8 and A.14; FAMIS Regulations, 12VAC30-141-650(C) and 12VAC30-141-870(C)*)

2.11.2 Provider shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to its premises to inspect, audit, monitor or otherwise evaluate the performance of Provider's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested, Provider shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Provider's activities. All information so obtained will be accorded confidential treatment as provided under Applicable Law. (*Medallion 3.0 Contract, Section 14.1; FAMIS Contract, Section 14.1*)

2.12 Member Access to Records. Provider agrees to the requirements for maintenance and transfer of medical records stipulated in the applicable State Contract. Provider further agrees to make medical records available to Members and their authorized representatives within ten (10) working days of the record request. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.9*)

2.13 Provider Disclosures. Provider agrees to disclose the required information, at the time of application, credentialing, and/or recredentialing, and/or upon request, in accordance with 42 CFR § 455 Subpart B and relevant provisions of the applicable State Contract, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or Federal health care programs. See 42 CFR § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs. (*Medallion 3.0 Contract, Section 3.4.A, Section 13.3.A.II.c(v), and Attachment III; FAMIS Contract, Section 3.4.A and Section 13.3.A.II.c(v)*)

2.14 Confidentiality of Family Planning Services. Provider agrees to ensure confidentiality of family planning services in accordance with the applicable State Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.10*)

2.15 No Barriers to Care. Provider agrees to not create barriers to access to care by imposing requirements upon Members that are inconsistent with the provision of Medically Necessary and covered Medicaid/FAMIS services. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.11*)

2.16 Provider Referrals and Hold Harmless. Provider agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts. Additionally, Provider hereby agrees that, if there is an intermediary organization between the Company and the Provider, the hold harmless requirement set forth in Section 4.3.2 of the Agreement shall include nonpayment by the Plan, the Company, and the intermediary organization. Provider further agrees that the hold harmless requirement applies in circumstances where Provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. (*Virginia Code § 38.2-5805(C)(10); Medallion 3.0 Contract, Section 12.9 and Attachment III; FAMIS Contract, Section 12.9 and Attachment III, Section A.12*)

2.17 Restriction on Billing Members. Provider agrees that the restrictions on billing Members as set forth in Section 4.3 of the Agreement shall continue to be in effect even if Company becomes insolvent. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.13*)

2.18 Prompt Provision of Covered Services. Provider shall promptly provide or arrange for the provision of all services required under the Agreement. This provision shall continue to be in effect for subcontract periods for which payment has been made even if Provider becomes insolvent until such time as the Members are withdrawn from assignment to Provider. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.15*)

2.19 PCP Obligation to Continue Services after Disenrollment. Except in the case of death or illness, Provider, if serving as a PCP, agrees to notify Company at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel Members for up to thirty (30) days after such notification, until another

PCP is chosen or assigned. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.16*)

2.20 PCP Panel. Providers serving as a PCP pursuant to the Agreement agree to act as a PCP for the predetermined number of Members set forth on the PCP Panel Schedule attached hereto, not to exceed the panel size limits set forth in the applicable State Contract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.17*)

2.21 Timeframe for Payment. Company agrees to pay Provider within thirty (30) days of the receipt of a claim for Covered Services rendered to a covered Member unless there is a signed agreement with Provider that states another timeframe for payment that is acceptable to Provider. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.18*)

2.22 State Appropriations. Notwithstanding any other provision to the contrary, the obligations of Virginia shall be limited to annual appropriations by its governing body for the purposes of the subcontract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.19*)

2.23 Confidentiality of Medical Records. For all referrals that require the sharing of a Member's medical information, Provider shall obtain necessary written and signed informed consent from Member prior to release of Member's medical information. All requests for medical information shall be consistent with the confidentiality requirements of 42 CFR § Part 431, Subpart F. (*Medallion 3.0 Contract, Section 4.12.B; FAMIS Contract, Section 4.12.B*)

2.24 Member Rights. Provider shall comply with any Applicable Laws that pertain to member rights. (*Medallion 3.0 Contract, Section 6.9; FAMIS Contract, Section 6.9*)

2.25 Emergency Services (Hospitals Only). In accordance with Section 1867 of the Social Security Act, if Provider is a hospital that offers Emergency Services, Provider shall perform a medical screening examination on all people who come to Provider seeking emergency care, regardless of their insurance status or other personal characteristics. If an Emergency Medical Condition is found to exist, Provider must provide whatever treatment is necessary to stabilize that condition. Provider may not transfer a patient in an unstabilized emergency condition to another facility unless the medical benefits of the transfer outweigh the risks, and the transfer conforms to all applicable requirements. (*Medallion 3.0 Contract, Section 7.2.G; FAMIS Contract, Section 7.2.G*)

2.26 Immunization Registry Database. To the extent possible, and as permitted by Virginia statute and regulations, Provider shall participate in the state-wide immunization registry database. (*Medallion 3.0 Contract, Section 7.2.J; FAMIS Contract, Section 7.2.J*)

2.27 Members with Disabilities. Provider must ensure that Members with disabilities have effective communication with health care system participants in making decisions with respect to treatment options. (*Medallion 3.0 Contract, Section 7.6.A.V; FAMIS Contract, Section 7.6.A.V*)

2.28 Maternity Care. Provider shall screen pregnant women (or refer to an appropriate practitioner to screen) for prenatal depression in accordance with the American College of Obstetricians and Gynecologists (ACOG) standards. (*Medallion 3.0 Contract, Section 8.7.A; FAMIS Contract, Section 8.7.A*)

2.29 Company Right to Assess Claims of Fraud. Provider shall cooperate with Company in its process for assessing claims of fraudulent activity by Members and providers. Company may utilize, among other methods, computer software and periodic audits of medical records to perform such audits. (*Medallion 3.0 Contract, Section 9.2; FAMIS Contract, Section 9.2*)

2.30 Provider Appeals. Provider must utilize and exhaust Company's internal appeals process as set forth in the Agreement before appealing to DMAS. (*Medallion 3.0 Contract, Section 10.2.B; FAMIS Contract, Section 10.2.A*)

2.31 Provider Identifiers. In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, Company shall assign a unique identifier to Provider, and Provider shall use this identifier when submitting data to Company. (*Medallion 3.0 Contract, Section 11.4; FAMIS Contract, Section 11.4*)

2.32 Provider Bankruptcy. Provider shall notify Company of any bankruptcy filing on or before the date of such filing. (*Medallion 3.0 Contract, Section 14.29.B.VI; FAMIS Contract, Section 14.29.B.VI*)

3.0 COMMONWEALTH OF VIRGINIA STATUTORY AND REGULATORY REQUIREMENTS

3.1 Health Care Provider Panels.

3.1.1 For a period of at least 90 days from the date of the notice of Provider's termination from Company's provider panel, except when Provider is terminated for cause, Provider shall be permitted by Company to render health care services to any Members who were in an active course of treatment from Provider prior to the notice of termination and request to continue receiving health care services from Provider. (*Virginia Code § 38.2-3407.10(F)(1)*)

3.1.2. Notwithstanding the provisions of 3.1.1, Provider shall be permitted to continue rendering health services to any Member who has entered the second trimester of pregnancy at the time of Provider's termination of participation, except when Provider is terminated for cause. Such treatment shall, at the Member's option, continue through the provision of postpartum care directly related to the delivery. (*Virginia Code § 38.2-3407.10(F)(2)*)

3.1.3 Notwithstanding the provisions of 3.1.1, Provider shall be permitted to continue rendering health services to any Member who is determined to be terminally ill (as defined under § 1861 (dd)(3)(A) of the Social Security Act) at the time of Provider's termination of participation, except when Provider is terminated for cause. Such treatment shall, at the Member's option, continue for the remainder of the Member's life for care directly related to the treatment of the terminal illness. (*Virginia Code § 38.2-3407.10(F)(3)*)

3.2 Medically Necessary Services. Nothing contained in this Addendum or in the Agreement shall be construed to require Provider to deny Covered Services that Provider knows to be Medically Necessary and appropriate that are provided with respect to a specific Member or group of Members with similar medical conditions. (*Virginia Code § 38.2-4312(F)*)

3.3 Limitation on Remedies. None of Provider, its agents, trustees, or assignees may maintain any action at law against a Member to collect sums owed by Company or any intermediary organization between Company and Provider. (*Virginia Code § 38.2-5805(C)(2) and (5)*)

3.4 Urgent Care and Emergency Services. Provider shall allow its Members, on a 24-hour basis, (i) access to medical care or (ii) access by telephone to a physician or licensed health care professional with appropriate medical training who can refer or direct a Member for prompt medical care in cases where there is a need for urgent care or Emergency Services. Provider shall clearly notify Members of provisions for urgent care or Emergency Services when Provider is not available after hours. (*12VAC5-408-280(A) and (C)*)

4.0 REGULATORY REQUIREMENTS SPECIFIC TO MEDALLION 3.0 MANAGED CARE PLANS

4.1 Compliance with Quality of Care Standards. Provider shall comply, and cause its employees, agents, independent contractors and subcontractors to comply, with all applicable federal and state mandates, community standards for quality of care, and standards developed pursuant to the DMAS managed care quality program. (*12VAC30-120-380(E)*)

4.2 Cost-Sharing. In accordance with 42 CFR § 447.50 through 42 CFR § 447.60, no provision contained in this Addendum or in the Agreement shall be construed to impose any cost sharing obligations on Members except as set forth in 12VAC30-20-150 and 12VAC30-20-160. (*12VAC30-120-380(I)*)

Exhibit B
Company Affiliates

Affiliate Name	Address	City	State	Zip
Aetna Better Health Inc. dba Aetna Better Health of Illinois	333 West Wacker Drive, Suite 2100	Chicago	Illinois	60606
Coventry Health and Life Insurance Company dba CoventryCares of Kentucky	9900 Corporate Campus Drive, Suite 1000	Louisville	Kentucky	40223
Aetna Better Health, Inc. dba Aetna Better Health of Louisiana	2400 Veterans Memorial Blvd., Suite 200	Kenner	Louisiana	70062
Aetna Better Health of Missouri LLC	10 South Broadway #1200	St. Louis	Missouri	63102
Coventry Health Care of Nebraska, Inc. d/b/a Aetna Better Health of Nebraska	15950 W. Dodge Rd.	Omaha	Nebraska	68118
Aetna Better Health Inc. dba Aetna Better Health of New Jersey	3 Independence Way, Suite 400	Princeton	New Jersey	08050
Aetna Better Health Inc. dba Aetna Better Health of Ohio	7400 West Campus Drive	New Albany	Ohio	43054
Aetna Better Health Inc. dba Aetna Better Health of Pennsylvania	2000 Market St., Suite 850	Philadelphia	Pennsylvania	19103
Aetna Health Inc. dba Aetna Better Health Kids	2000 Market St., Suite 850	Philadelphia	Pennsylvania	19103
Aetna Health Inc. dba Aetna Better Health (a Texas corporation)	2777 Stemmons Freeway Suite 300	Dallas	Texas	75207
Coventry Health Care of Virginia, Inc. dba CoventryCares of Virginia	9881 Mayland Dr.	Richmond	Virginia	23233

TENTH AMENDMENT TO THE
RADIOLOGY MANAGEMENT SERVICES AGREEMENT

This Amendment ("Amendment") is effective May 1, 2016 (the "Effective Date"), and is by and between **Aetna Medicaid Administrators LLC,** on behalf of itself and its affiliates ("Aetna"), and **MedSolutions, Inc. d/b/a eviCore healthcare,** on behalf of itself and its affiliates ("Delegated Entity"). Aetna and Delegated Entity may each be referred to individually as a "Party" and collectively as the "Parties."

WHEREAS, Aetna entered into a Radiology Management Services Agreement with Delegated Entity, dated as of January 1, 2014 (the "Agreement"), for the provision of health care services to, and/or administrative or health-benefit management services/functions relating to, the members of Aetna and/or its affiliates; and

WHEREAS, Company and Delegated Entity have since amended the Agreement on or around the following dates: First Amendment on April 1, 2014 (adding musculoskeletal pain management services); Second Amendment on April 1, 2014 (adding Maryland and Pennsylvania regulatory addenda); Third Amendment was never executed and is intentionally omitted; Fourth Amendment on July 16, 2014 (adding Missouri and Michigan); Fifth Amendment originally executed on May 1, 2015 and re-executed on October 19, 2015 (adding Louisiana); Sixth Amendment on May 1, 2015 (revising musculoskeletal pain management rates and adding Ohio regulatory addenda); and Seventh Amendment on December 15, 2015 (revising compensation terms, updating Michigan and Louisiana regulatory addenda, and adding Kentucky and Virginia); and

WHEREAS, the Parties desire to amend the Agreement further to include certain additional terms associated therewith.

NOW, THEREFORE, in consideration of the mutual covenants and promises stated herein and other good and valuable consideration, and intending to be legally bound, the Parties agree as follows:

1. The Agreement is hereby amended to add and incorporate in their entirety the following Regulatory Compliance Addenda that are attached to this Amendment:

    a. Addendum A—Regulatory Compliance Addendum Governing Illinois Medicaid Services; and

    b. Addendum B—Regulatory Compliance Addendum Governing Medicare-Medicaid Dual-Eligible Services (Aetna Better Health of Illinois).

    Delegated Entity agrees to perform its obligations under the Agreement in accordance with the terms and conditions set forth in the aforementioned Regulatory Compliance Addenda to the extent that those terms and conditions are applicable to Delegated Entity's services and obligations under the Agreement. In the event of any conflict between the terms of the attached Regulatory Compliance Addenda, on the one hand, and any of the other terms of the Agreement, on the other hand, including any other attachments, schedules, exhibits, and/or addenda that are currently appended to the Agreement, the terms of the Regulatory Compliance Addenda attached to this Amendment shall govern and control to the extent applicable to Delegated Entity's services and obligations under the Agreement.

    For the avoidance of doubt, Addendum A attached hereto shall supersede and replace "Individual Sites Regulatory Addendum – Exhibit A ILLINOIS," which is currently appended to the Agreement. Furthermore, Addendum B attached hereto shall supersede and replace "Exhibit D – Addendum for Medicare-Medicaid Dual Eligible Members," which is currently appended to the Agreement, with respect to the services and obligations that Delegated Entity provides under the Agreement relating to the Medicare-Medicaid plans of Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois.

2. This Amendment may be executed in one or more counterparts, each of which shall constitute an original and all of which together shall constitute one and the same Amendment.

3. The Parties ratify and affirm the Agreement, and agree that all other terms and provisions of the Agreement not amended herein shall remain in full force and effect, without modification. In the event of any inconsistency between the terms of this Amendment and the Agreement, the terms of this Amendment shall govern and control.

IN WITNESS WHEREOF, the undersigned Parties have executed this Amendment by their duly authorized officers, intending to be legally bound hereby, as of the Effective Date indicated above.

AETNA

Signature

Robert M. Kessler

Printed Name

Secretary

Title

April 28, 2016

Date

DELEGATED ENTITY

Signature

Alan Poenitske

Printed Name

Chief Accounting Officer

Title

4.21.16

Date

ADDENDUM A

Regulatory Compliance Addendum
Governing Illinois Medicaid Services

This Regulatory Compliance Addendum Governing Illinois Medicaid Services (the "Illinois Medicaid Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under, as well as the provision of any administrative or health-benefit management services/functions that relate to, as applicable:

(1) the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health Inc., an Illinois Corporation, for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization*, Contract No. 2015-24-004 (ABH) f/k/a Contract No. 2010-24-005-K, effective on or about May 1, 2011, which governs the program known as the Illinois Integrated Care Program a/k/a the ICP (the "ICP Contract"); and/or

(2) the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health for Furnishing Health Services by a Managed Care Organization*, Contract No. 2015-24-002, effective on or about August 1, 2014, which governs the program known as the Illinois Family Health Plan Population–Affordable Care Act Adult program a/k/a FHP-ACA program (the "FHP-ACA Contract").

Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois ("Company") serves as a managed-care organization under both the ICP Contract and the FHP-ACA Contract (the "State Contracts") on behalf of the State of Illinois and its Department for Healthcare and Family Services ("HFS" and collectively, the "State").

The State requires that specific terms and conditions be incorporated into the Agreement. As such, this Illinois Medicaid Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof), and such provider, vendor, contractor, or other entity must comply with the requirements set forth herein. Note that this Illinois Medicaid Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in the policies, procedures, and provider manual of Company (or its Affiliate, as the case may be). This Illinois Medicaid Addendum and the Agreement may be revised as directed by the State.

For purposes of this Illinois Medicaid Addendum, the individuals who are enrolled with Company under the State Contracts will be referred to as the "Enrollees." All capitalized terms not defined in this Illinois Medicaid Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Illinois Medicaid Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Illinois Medicaid Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contracts and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contracts. Except as provided herein, all other provisions of the Agreement not inconsistent with this Illinois Medicaid Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Illinois Medicaid Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The provider, vendor, contractor, or other entity identified on the first page of the Agreement acknowledges and agrees that all provisions of this Illinois Medicaid Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members who are eligible and covered under the State Contracts, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the State Contracts, and it/they represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Illinois Medicaid Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

A. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this Illinois Medicaid Addendum:

a. "Authorized Persons" – Collectively means HFS, HFS's Office of Inspector General ("HFS OIG"), the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, the United States Department of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS"), and any other State or federal agencies with monitoring authority related to Medicaid. [ICP Contract § 1.19; FHP-ACA Contract § 1.20]

b. "Provider" – Means any individual or entity that is enrolled with the State to provide Covered Services to Enrollees and that is associated with Company pursuant to a written contract or agreement for the purpose of providing health care services under the State Contracts. [ICP Contract §§ 1.16, 1.118; FHP-ACA Contract §§ 1.16, 1.17, 1.122]

c. "Subcontractor" – Means any individual or entity, other than a Provider, with which Company has entered into a written agreement for the purpose of delegating responsibilities applicable to Company under the State Contracts. [ICP Contract § 1.144; FHP-ACA Contract § 1.148]

B. Requirements Applicable to State Contracts and Covered Services

1. Practice Coverage and Hours; Enrollee Appointments. Provider agrees to provide Covered Services to Enrollees as set forth in the Agreement, including without limitation the following when such Covered Services are specified in the Agreement:

a. Primary care providers (PCPs) and specialty Providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after-hours telephone number (after-hours voicemail alone is not acceptable). [ICP Contract § 5.6.4; FHP-ACA Contract § 5.7.4]

b. Provider shall offer to Enrollees hours of operation that are no less than the hours of operation offered to persons who are not Enrollees. [ICP Contract § 5.6.3; FHP-ACA Contract § 5.7.3]

c. Provider shall ensure that time-specific appointments for routine, preventive care to an Enrollee are available within five (5) weeks from the date of request for such care, and within two (2) weeks from the date of request for infants under age six (6) months. If an Enrollee has more serious problems that are not deemed emergency medical conditions, Provider shall triage that Enrollee and, if necessary or appropriate, immediately refer that Enrollee for urgent medically necessary care or provide that Enrollee with an appointment within one (1) business day of the request. If an Enrollee has a problem or complaint that is not deemed serious, Provider shall see that Enrollee within three (3) weeks from the date of request for such care. If Enrollee seeks an initial prenatal visit without expressed problems, the Provider shall see that Enrollee within two (2) weeks after a request if the Enrollee is in her first trimester, within one (1) week if the Enrollee is in her second trimester, and within three (3) days if the Enrollee is in her third trimester. [ICP Contract § 5.6.3; FHP-ACA Contract § 5.7.3]

2. Payments; Hold Harmless of Enrollees/State.

a. Provider/Subcontractor acknowledges and agrees that Company shall not pay a Provider/Subcontractor for any provider-preventable condition. Provider/Subcontractor shall report all provider-preventable conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made. [FHP-ACA Contract § 5.25.8]

b. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state plan or waiver.

c. Except as permitted or required by HFS in 89 Ill. Adm. Code 125, in HFS's fee-for-service copayment policy in effect at the time Covered Services are provided, and/or in the State Contracts, neither Company nor Provider/Subcontractor may seek or obtain funding through fees or charges to any Enrollee receiving Covered Services under the State Contracts. Provider/Subcontractor furthermore acknowledges and agrees that imposing charges in excess of those permitted under the State Contracts is a violation of Section 1128B(d) of the Social Security Act and subjects the party imposing such charges to criminal penalties. [ICP Contract § 5.30; FHP-ACA Contract § 5.30]

d. Provider/Subcontractor agrees that in no event, including but not limited to the nonpayment by Company of amounts due to Provider/Subcontractor under the Agreement, the insolvency of Company, or any breach of the Agreement by Company, shall Provider/Subcontractor or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against the Enrollee or persons acting on the Enrollee's behalf (other than Company) for services provided pursuant to the Agreement except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Enrollees and all persons acting on the Enrollees' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider/Subcontractor and the Enrollee or persons acting on the Enrollee's behalf (other than Company). [215 ILCS 125/2-8(a)]

e. Any dispute between Company and Provider/Subcontractor shall be solely between those parties, and Company and Provider/Subcontractor shall each hold harmless the State and its agencies, officers, employees, agents, and volunteers from and against such dispute and any and all liabilities, demands, claims, suits, losses, damages, causes of action, fines, or judgments, including costs, attorneys' and witnesses' fees, and expenses incident thereto, regardless of the reason. [ICP Contract §§ 7.13, 9.1.8, 9.1.28; FHP-ACA Contract §§ 7.13, 9.1.8, 9.1.28]

3. Standards of Care. In addition to complying with other applicable standards of care, Provider/Subcontractor shall:

a. Timely identify any Enrollees with high-risk pregnancies and arrange for a maternal fetal medicine specialist or a transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements for referral and/or transfer of high-risk women. [ICP Contract, Attachment XXI ¶ 3.c.i.D; FHP-ACA Contract, Attachment XXI ¶ 3.c.i.D]

b. Cooperate and communicate with other service providers who serve Enrollees, including without limitation Special Supplemental Nutrition Programs for Women, Infants, and Children (commonly referred to as "WIC" programs); Head Start programs; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the Enrollee). [ICP Contract, Attachment XXI ¶ 3.e.i.; FHP-ACA Contract, Attachment XXI ¶ 3.e.i.]

4. Cultural Competence; Prohibition on Discrimination. In addition to complying with other applicable standards:

a. Provider/Subcontractor shall cooperate in the implementation of, and comply with all requirements set forth in, Company's Cultural Competence Plan, which shall include implementation of the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). Provider/Subcontractor acknowledges and agrees that all Covered Services shall be provided in a culturally competent manner by ensuring the cultural competence of all Provider/Subcontractor staff, from clerical to

executive management. Furthermore, Subcontractors shall complete Company's initial and annual cultural-competence training. [ICP Contract §§ 2.7, 2.7.3, 2.7.4; FHP-ACA Contract §§ 2.7, 2.7.3, 2.7.4]

b. Provider/Subcontractor shall abide by all federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Illinois Human Rights Act, and Executive Orders 11246 and 11375. Provider/Subcontractor furthermore agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Agreement. Provider/Subcontractor will furthermore not discriminate against Enrollees or prospective or potential Enrollees on the basis of health status, need for health services, or payment source. All Provider/Subcontractor locations where Enrollees receive Covered Services shall comply with the Americans with Disabilities Act of 1990. [77 Ill. Admin. Code § 240.50(d)(4); ICP Contract §§ 2.8, 5.6.2, 9.1.22; FHP-ACA Contract §§ 2.8, 5.7.2, 9.1.22]

5. Anti-Gag Clause; Prohibition on Retaliation. Provider/Subcontractor shall not be prohibited or otherwise restricted or discouraged from, and shall not prohibit or otherwise restrict or discourage its downstream providers or subcontractors from, taking any of the following actions so long as those actions are within the lawful scope of the acting party's practice: (a) advocating for medically appropriate health care services for Enrollees, which may include without limitation appealing denials and protesting decisions, policies, and practices; (b) advising an Enrollee about the health status of that Enrollee or medical care or treatment for that Enrollee's condition or disease regardless of whether benefits for such care or treatment are provided under the Agreement and/or the State Contracts; and/or (c) discussing with Enrollees, prospective Enrollees, or the public any health care services, health care providers, utilization review policies, quality assurance policies, or terms and conditions of plans and plan policy. Furthermore, Company shall not retaliate against Provider/Subcontractor, and Provider/Subcontractor shall not retaliate against its downstream providers or subcontractors, for any of the foregoing actions. Notwithstanding the foregoing, nothing in this provision shall be construed to prohibit: (a) Company or Provider/Subcontractor from making a determination not to pay for a particular health care service, from enforcing reasonable peer review or utilization review protocols, or from determining whether a physician or other health care provider has complied with those protocols; and/or (b) a Provider that is a hospital from taking disciplinary actions against a physician as authorized by law. [215 ILCS 134/30(a); 215 ILCS 134/35(a)–(d); ICP Contract § 5.32; FHP-ACA Contract § 5.32]

6. Grievances and Appeals. Provider/Subcontractor shall comply with Company's grievance and appeal processes referenced in the Agreement, and Company shall notify Provider/Subcontractor within fifteen (15) days following any substantive change to such procedures. [ICP Contract § 5.28.6; FHP-ACA Contract § 5.28.6]

7. Data and Reporting.

a. Provider/Subcontractor shall submit all data, reports, and clinical information required by Company under the State Contracts in such manner and format, and pursuant to such timeframes, as requested by Company and/or HFS. Provider/Subcontractor shall ensure that all data and reports that it submits to Company are accurate and complete, and Provider/Subcontractor furthermore acknowledges and agrees that all such data and reports shall be available to HFS and, upon request, to federal CMS. [ICP Contract § 5.24; FHP-ACA Contract § 5.24]

b. If Provider/Subcontractor provides Covered Services to Enrollees under a Illinois Department of Human Services ("DHS") Home and Community-Based Services ("HCBS") Waiver, under the Medicaid Clinic Option, or under the Medicaid Rehabilitation Option, or provides subacute alcoholism and substance-abuse treatment services pursuant to 89 Ill. Admin. Code §§ 148.340–148.390 and 77 Ill. Admin. Code Part 2090, such Provider/Subcontractor shall enter any data regarding Enrollees that is required under State rules, or under a contract between the Provider/Subcontractor and DHS, into any subsystem maintained by DHS, including, but not limited to, DHS's Automated Reporting and Tracking System (DARTS). [FHP-ACA Contract § 5.28.1.3]

8. Delegation. If Company delegates to Provider/Subcontractor any activities or obligations under the State Contracts:

a. Company shall remain ultimately responsible for the performance of those responsibilities and nothing in the Agreement shall be construed to terminate Company's legal responsibility to DHS to assure that all activities under the State Contracts are carried out. [ICP Contract §§ 5.28.2, 5.28.3; FHP-ACA Contract §§ 5.28.2, 5.28.3]

b. Provider/Subcontractor acknowledges and agrees that Company's delegated oversight committee will oversee Provider/Subcontractor's activities and performance under the Agreement to ensure compliance with all applicable contractual and statutory requirements, including without limitation the Illinois Human Rights Act, the U.S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act. Company's oversight of Provider/Subcontractor will include, without limitation: pre-delegation audits; quarterly delegation oversight reviews of delegate performance; monthly joint-operation meetings; annual audits of Provider/Subcontractor; regular monitoring of Enrollee complaints with respect to Provider/Subcontractor; and documentation of issues and development of a corrective action plan, as warranted, to improve performance. [ICP Contract § 2.7.4; FHP-ACA Contract § 2.7.4]

c. To the extent that such delegated activities are credentialing or recredentialing activities or obligations under the State Contracts, Provider/Subcontractor shall maintain a formal credentialing program and shall conduct all such activities or obligations in compliance with Company, National Committee for Quality Assurance (NCQA), and State standards. Company shall monitor such credentialing/recredentialing delegated activities and shall review Provider/Subcontractor's credentialing files no less than annually as part of the annual audit. [ICP Contract § 5.7.4, Attachment XI ¶ 7.e.; FHP-ACA Contract § 5.8.4, Attachment XI ¶ 7.e.]

9. Quality Assurance. With respect to Company's quality-assurance obligations under the State Contracts:

a. Provider/Subcontractor shall participate in and cooperate with Company's quality-assurance program (QAP), shall cooperate with Company with respect to Company's QAP obligations under the State Contracts, and shall cooperate with Company's quality improvement committee. Provider/Subcontractor shall furthermore allow Company to access Provider/Subcontractor's Enrollee medical records to permit effective quality review, and such access shall include the right of Company to make and/or obtain a copy (in either electronic or hardcopy form) of such records. [ICP Contract, Attachment XI ¶ 6.b.; FHP-ACA Contract, Attachment XI ¶ 6.b.]

b. Provider/Subcontractor shall provide, arrange for, or participate in the quality-assurance programs mandated by the Illinois Health Maintenance Organization Act, unless the Illinois Department of Public Health has certified that such programs will be fully implemented without any participation or action from Provider/Subcontractor. [215 ILCS 125/2-8(a); 50 Ill. Admin. Code § 5241.50(a)(4)]

c. Provider/Subcontractor acknowledges and agrees that Company shall perform quality-assurance evaluations of Provider/Subcontractor's practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. [ICP Contract § 2.7.5; FHP-ACA Contract § 2.7.5]

d. Provider/Subcontractor shall cooperate and comply with all remedial or corrective actions that Company implements with respect to Provider/Subcontractor and/or its services under the Agreement, upon Company's determination that Provider/Subcontractor has furnished inappropriate or substandard services or has failed to furnish services that should have been furnished. [ICP Contract, Attachment XI ¶ 3.e.; FHP-ACA Contract, Attachment XI ¶ 3.e.]

e. If Company delegates to Provider/Subcontractor any quality-assurance activities or obligations that Company has under the State Contracts:

(i) Company and Provider/Subcontractor shall agree in writing upon the delegated activities, the accountability of Provider/Subcontractor for those activities, and the frequency of Provider/Subcontractor's reporting to Company related to those activities. [ICP Contract, Attachment XI ¶ 7.a.; FHP-ACA Contract, Attachment XI ¶ 7.a.]

(ii) Company and Provider/Subcontractor shall agree in writing upon the standards and procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided. [ICP Contract, Attachment XI ¶ 7.b.; FHP-ACA Contract, Attachment XI ¶ 7.b.]

(iii) All such delegated activities shall conform to the requirements set forth in the State Contracts. [ICP Contract, Attachment XI ¶ 7.c.; FHP-ACA Contract, Attachment XI ¶ 7.c.]

(iv) Provider/Subcontractor acknowledges and agrees that Company shall engage in continuous and ongoing evaluation and oversight of such delegated activities, including approval of quality-improvement plans and regular specified reports, as well as a formal review of such activities. Company's oversight of Provider/Subcontractor's performance of these delegated activities must include no less than an annual audit, analyses of required reports and encounter data, a review of Enrollee complaints, grievances, Provider complaints, and quality of care concerns raised through encounter data, monitoring activities, or other venues. Outcomes of Company's annual audit shall be submitted to HFS as part of Company's QA/UR/PR Annual Report. [ICP Contract, Attachment XI ¶ 7.d.; FHP-ACA Contract, Attachment XI ¶ 7.d.]

(v) If Company or Provider/Subcontractor identifies areas requiring improvement, Company or Provider/Subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, Provider/Subcontractor must develop and implement a corrective action plan, with protections put in place by Company to prevent such deficiencies from recurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to HFS through quarterly or annual reporting. [ICP Contract, Attachment XI ¶ 7.f.; FHP-ACA Contract, Attachment XI ¶ 7.f.]

10. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy-related Covered Services:

a. Provider/Subcontractor shall administer all pharmacy benefits in accordance with the provisions and requirements of the State Contracts and all applicable State and federal laws and regulations. [ICP Contract §§ 5.1.7, 5.16.6; FHP-ACA Contract §§ 5.2.5, 5.16.6]

b. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contracts to submit required pharmacy-related reports and data to applicable federal and State authorities. [ICP Contract, Attachment XIII; FHP-ACA Contract, Attachment XIII]

c. If Company delegates to Provider/Subcontractor any pharmacy-related activities or obligations that Company has under the State Contracts, Provider/Subcontractor shall comply with all pharmacy-related provisions and requirements set forth in the State Contracts, including without limitation the following, as applicable:

(i) Company and Provider/Subcontractor shall submit a pharmacy formulary for prior approval by the State initially and annually thereafter. [ICP Contract § 5.1.7; FHP-ACA Contract § 5.2.5]

(ii) Company and Provider/Subcontractor shall provide coverage of drugs in all classes of drugs for which HFS's fee-for-service program provides coverage. [ICP Contract § 5.1.7.1; FHP-ACA Contract § 5.2.5.1]

(iii) Company and Provider/Subcontractor shall cover only drugs made by manufacturers that participate in the federal Medicaid drug rebate program, which applies to both prescription and over-the-counter drugs, but does not apply to non-drug items such as blood sugar test strips. HFS will provide a listing of manufacturers that participate in the federal Medicaid drug rebate program. [ICP Contract § 5.1.7.2; FHP-ACA Contract § 5.2.5.2]

(iv) Company and Provider/Subcontractor may determine their own utilization controls, including without limitation step therapy and prior approval, unless otherwise prohibited under the State Contracts, to ensure appropriate utilization. Company and Provider/Subcontractor shall utilize HFS's step-therapy and prior-authorization requirements for family-planning drugs and devices as set forth in the State Contracts. [ICP Contract § 5.1.7.3; FHP-ACA Contract § 5.2.5.3]

(v) Company and Provider/Subcontractor shall ensure that they require pharmacy, medical, and hospital providers to identify 340B-purchased drugs on pharmacy, medical, and hospital claims following HFS billing guidelines applied in HFS's fee-for-service program, and Company and Provider/Subcontractor shall furthermore ensure that its encounter claims to HFS identify these drugs. [ICP Contract § 5.1.7.4; FHP-ACA Contract § 5.2.5.4] For any outpatient drugs *not* identified in accordance with the previous sentence: (i) Company and Provider/Subcontractor shall collect information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees, and (ii) Company and Provider/Subcontractor shall report to HFS quarterly, in a format and in the detail specified by HFS, information on the total number of units of each dosage form and strength and package size by National Drug Code of each such covered outpatient drug dispensed to Enrollees. [FHP-ACA Contract §§ 5.2.5.4.1, 5.2.5.4.2]

(vi) Company and Provider/Subcontractor shall establish and maintain a generic drug Maximum Allowable Cost (MAC) dispute-resolution process, subject to approval by HFS. The MAC dispute-resolution process shall enable pharmacies to report pricing disputes to the Company and/or Provider/Subcontractor up to sixty (60) days from the claim date and Company and/or Provider/Subcontractor is required to resolve the pricing dispute within twenty-one (21) days by adjusting the reimbursement rate to represent the average acquisition cost of the drug, or by informing the pharmacy of alternative generic equivalent products that can be purchased at or below the Company's existing MAC price. [ICP Contract § 5.1.7.5; FHP-ACA Contract § 5.2.5.5]

(vii) Company and Provider/Subcontractor shall develop and implement a system, including policies and procedures, coverage criteria, and processes for their Drug Utilization Review (DUR) program. The DUR program shall include a prospective review process for all drugs prior to dispensing and all non-formulary drug requests, and a retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. Company and Provider/Subcontractor are required to report prospective and retrospective DUR activities to HFS quarterly, and to assist in data collection and reporting to HFS of data necessary to complete the federal CMS DUR annual report. [ICP Contract § 5.1.7.6; FHP-ACA Contract § 5.2.5.6]

(viii) Company and Provider/Subcontractor shall comply with the pharmacy prior-authorization provisions and requirements set forth in Section 5.16.6 of each of the State Contracts, which requires that Company and/or Provider/Subcontractor must authorize or deny a prior-authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization. [ICP Contract § 5.16.6; FHP-ACA Contract § 5.16.6]

(ix) Company and Provider/Subcontractor shall not permit or allow, whether by contract, written policy, or procedure, any individual or entity to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person

ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act (codified at 410 ILCS 620/3.14). [215 ILCS 134/30(b)]

11. Children's Mental Health Service Requirements. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to any behavioral-health Covered Services that Provider/Subcontractor provides to Enrollees under the age of twenty one (21):

a. Provider/Subcontractor shall administer all such behavioral-health benefits in accordance with the provisions and requirements of Attachment XXII of the FHP-ACA Contract and in accordance with all applicable State and federal laws and regulations. [FHP-ACA Contract, Attachment XXII]

b. If Provider is an inpatient psychiatric Provider, it shall administer a physical examination to the Enrollee within twenty-four (24) hours after admission when that Enrollee requires admission to an appropriate inpatient institutional treatment setting. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.iv.]

c. Provider shall comply with Company's procedures with respect to discharge and transitional planning related to an appropriate inpatient institutional treatment setting, and shall cooperate with Company in the education and training of the Enrollee's family on how to use the "crisis safety plans" while the Enrollee is receiving inpatient institutional treatment. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.v.5.]

d. If Provider/Subcontractor provides Mobile Crisis Response Services in connection with the State Contracts:

(i) Provider/Subcontractor shall ensure that the staff providing those services hold the following credentials: (a) Mental Health Professional (MHP) with direct access to a Qualified Mental Health professional; (b) Qualified Mental Health Professional; or (c) Licensed Practitioner of the Healing Arts. [FHP-ACA Contract, Attachment XXII, ¶ 3.f.]

(ii) Provider/Subcontractor shall provide immediate crisis and stabilization services when an Enrollee in crisis can be stabilized in the community. [FHP-ACA Contract, Attachment XXII, ¶ 4.a.i.]

(iii) Provider/Subcontractor shall establish a "crisis safety plan" for all Enrollees presenting in behavioral-health crisis that is unique to the Enrollee and the circumstances leading to the crisis situation. [FHP-ACA Contract, Attachment XXII, ¶¶ 4.a.ii., 4.b.i.]

(iv) Provider/Subcontractor shall provide the Enrollee's family with contact information that may be used at any time, 24 hours a day, to contact Company in moments of crisis. [FHP-ACA Contract, Attachment XXII, ¶ 4.a.iv.]

(v) Provider/Subcontractor shall provide families of Enrollees with physical copies of the "crisis safety plan" (a) prior to the completion of the crisis screening event for any Enrollee stabilized in the community, and (b) prior to discharge of the Enrollee from an inpatient psychiatric hospital for any Enrollee that is admitted to such a facility. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.ii.]

(vi) Provider/Subcontractor shall educate and orient the Enrollee's family to the components of the "crisis safety plan" to ensure that the plan is reviewed with the family regularly, and to detail how the plan is updated as necessary. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.iii.]

(vii) Provider/Subcontractor shall share the "crisis safety plan" with all necessary medical professionals, including care coordinators, consistent with the authorizations established by consent or release. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.iv.]

(viii) Provider/Subcontractor shall facilitate the Enrollee's admission to an appropriate inpatient institutional treatment setting when the Enrollee in crisis cannot be stabilized in the community. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.i.]

(ix) Provider/Subcontractor shall inform the Enrollee's parents, guardian, caregivers, or residential staff about all of the available service providers and pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.ii.]

12. Third Party Liability. Provider/Subcontractor acknowledges and agrees that Medicaid payment, under the State Contracts or otherwise, is secondary to other sources of payment for Covered Services provided to Enrollees, and that Medicaid (and consequently Company, as a Medicaid MCO of the State) is the payer of last resort. Provider/Subcontractor furthermore acknowledges and agrees that when Company is aware of third-party sources of payment for Covered Services, Company is required to "cost avoid" (*i.e.*, deny) the associated claim and to redirect Provider/Subcontractor to bill that third-party source of payment as the primary payor.

13. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to submit financial and expense-related reports/data to the State relating to the risk adjustment and Medical Loss Ratio (MLR) adjustment set forth in the State Contracts. [ICP Contract §§ 7.4, 7.11; FHP-ACA Contract §§ 7.4, 7.11]

b. Company's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [ICP Contract §§ 9.1.37, 9.1.38; FHP-ACA Contract §§ 9.1.36, 9.1.37]

c. Company's obligation to provide a "medical home," as that term is used in the State Contracts, for its Enrollees. [ICP Contract §§ 5.5.7, 5.9.2; FHP-ACA Contract §§ 5.6.7, 5.9.2]

d. Company's obligation to encourage Provider/Subcontractor to support Enrollees in directing their own care and in development of the Enrollee's care plan. [ICP Contract § 5.12.6; FHP-ACA Contract § 5.14.5; 5.14.8.1.3]

e. Company's obligation to avoid unnecessary utilization of emergency services by Enrollees and to promote care management through the Enrollees' primary care providers (PCPs) or "medical home." [ICP Contract § 5.17.1.5; FHP-ACA Contract § 5.17.1.5]

f. Company's obligation to establish and maintain an HFS-approved peer-review program to review the quality of care that Provider/Subcontractor provides to Enrollees. [ICP Contract § 5.19.5; FHP-ACA Contract § 5.19.5]

g. Company's obligation to provide orientation, education, and training for Provider/Subcontractor as set forth in the State Contracts, including without limitation (i) training on how to identify, recognize potential concerns related to, and report on suspected or alleged abuse, neglect, and exploitation being suffered by Enrollees, and (ii) education on the application of required clinical guidelines. [ICP Contract §§ 5.9, 5.20.1, 5.20.2, Attachment XI ¶ 9, Attachment XXI ¶ 3; FHP-ACA Contract §§ 5.9, 5.20.4, 5.20.5, Attachment XI ¶ 9, Attachment XXI ¶ 3]

h. Company's obligation to participate in any State-required performance-improvement projects. [ICP Contract § 7.16.5; FHP-ACA Contract § 7.16.5]

i. Company's obligation to remit to Provider/Subcontractor, if applicable, any "hospital access payments" authorized under 305 ILCS 5/5A-12.2(s)–(t) and 305 ILCS 5/5A-12.5 (Public Act 98-651, enacted June 14, 2014). [ICP Contract § 7.1.5; FHP-ACA Contract § 7.1.2]

j. Company's obligation to respond to any letter of concern, written deficiency notice, or request for a corrective action plan that Company receives from the State relating to Provider/Subcontractor or the services that are within the scope of the Agreement. [ICP Contract § 7.16.6.1; FHP-ACA Contract § 7.16.6.1]

k. Company's obligations and responsibilities relating to the "HMO self-evaluation structure" and associated activities set forth in 77 Ill. Admin. Code § 240.60. [77 Ill. Admin. Code § 240.50(d)(1)(C)]

14. Notice of Legal Action. If Provider/Subcontractor, its parent, or one of its affiliates becomes a party to any litigation, investigation, or transaction that may reasonably be considered to have a material impact on Provider/Subcontractor's ability to perform under the Agreement, Provider/Subcontractor shall immediately notify Company in writing. [ICP Contract § 9.1.24; FHP-ACA Contract § 9.1.24]

15. State Review of Agreement. Provider/Subcontractor acknowledges and agrees that Company may be required to submit a copy of the Agreement to HFS for review, and that HFS reserves the right to require Company to amend the Agreement as reasonably necessary to conform to Company's duties and obligations under the State Contracts. [ICP Contract § 5.28.10; FHP-ACA Contract § 5.28.10]

16. Termination of Agreement and Effect Thereof.

a. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the parties. Furthermore, in the event this Illinois Medicaid Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or Product Participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties.

b. Notwithstanding anything in the Agreement to the contrary, if either Company or Provider/Subcontractor seeks (i) to terminate the Agreement "with cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least sixty (60) days' written notice to the other party; or (ii) to terminate the Agreement "without cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least ninety (90) days' written notice to the other party. Furthermore, Provider/Subcontractor shall cooperate with Company with respect to Company's obligation to provide timely notice to Enrollees of any termination that would curtail or eliminate services to such Enrollees, with such notice to be sent (i) at least sixty (60) days prior to that termination, or (ii) immediately, if Company receives less than sixty (60) days' notice of that termination from Provider/Subcontractor. The notice to be sent to Enrollees shall include instructions regarding referrals that have previously been issued and appointments that may be pending. [50 Ill. Admin. Code § 5241.50(a)(5)–(6); 305 ILCS 5/5F-40(a)]

c. Notwithstanding anything in the Agreement to the contrary, Company shall retain the right to terminate the Agreement, or impose other sanctions, if the performance of Provider/Subcontractor is inadequate. Company shall monitor the performance of Provider/Subcontractor on an ongoing basis, shall subject Provider/Subcontractor to formal review on no less than a triennial basis, and to the extent deficiencies or areas for improvement are identified during an informal or formal review, shall require Provider/Subcontractor to take appropriate corrective action. Furthermore, Company shall promptly terminate the Agreement if Provider/Subcontractor is or becomes terminated, barred, or suspended, or has voluntarily withdrawn as a result of a settlement agreement, under either Section 1128 or Section 1128A of the Social Security Act, from participating in any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act or are otherwise excluded from participation in the HFS Medical Program. [ICP Contract §§ 5.28.7, 5.28.9; FHP-ACA Contract §§ 5.28.7, 5.28.9]

17. Maintenance, Access to, and Confidentiality of Records.

a. Provider/Subcontractor shall maintain books and records relating to the performance of the State Contracts and the Agreement and necessary to support amounts charged under the State Contracts and the Agreement. Books and records, including information stored in databases or other computer systems, shall be maintained by Provider/Subcontractor for a period of three (3) years from the later of the date of final payment under the Agreement or completion of the Agreement, or such longer time as may be required by federal law or regulation. Books and records required to be maintained under this provision shall be accessible for review or audit by representatives of Company or any Authorized Persons (along with the Executive Inspector General and the Chief Procurement Officer) upon reasonable notice and during normal business hours. Such access shall include the right to make and/or obtain a copy (in either electronic or hardcopy form) of such books and records. Provider/Subcontractor shall cooperate fully with any such audit and with any investigation conducted by any of these entities. Failure to maintain the books and records required by this provision shall establish a presumption in favor of the State for the recovery of any funds paid by the State under the State Contracts for which adequate books and records are not available to support the purported disbursement. Provider/Subcontractor shall not impose a charge for audit or examination of Provider/Subcontractor's books and records. [ICP Contract § 9.1.2; FHP-ACA Contract § 9.1.2]

b. Provider/Subcontractor may have or gain access to confidential data or information owned or maintained by the State or Company in the course of carrying out Provider/Subcontractor's responsibilities under the Agreement and/or the State Contracts. Provider/Subcontractor shall presume all information received from the State or Company, or to which it gains access pursuant to the Agreement and/or the State Contracts, is confidential. No confidential data collected, maintained, or used in the course of performance of the Agreement and/or the State Contracts shall be disseminated except as authorized by law and with the written consent of the State and/or Company, as applicable, either during the term of the State Contracts or thereafter, unless otherwise expressly provided in the State Contracts. Provider/Subcontractor must return any and all data collected, maintained, created, or used in the course of the performance of the Agreement and/or the State Contracts, in whatever form it is maintained, promptly at the earlier of the termination of the Agreement or the termination of the State Contracts, or earlier at the request of the State, or notify the State and/or Company, as applicable, in writing of its destruction. The foregoing obligations shall not apply to confidential data or information that is: (i) lawfully in Provider/Subcontractor's possession prior to its acquisition from the State and/or Company; (ii) received in good faith from a third-party not subject to any confidentiality obligation to the State and/or Company; (iii) now is or later becomes publicly known through no breach of confidentiality obligation by Provider/Subcontractor; or (iv) is independently developed by Provider/Subcontractor without the use or benefit of the confidential information of the State and/or Company. [ICP Contract § 9.1.6; FHP-ACA Contract § 9.1.6]

c. Provider/Subcontractor shall ensure that all information, records, data, and data elements pertaining to applicants for and recipients of public assistance, or to providers, facilities, and associations, shall be protected from unauthorized disclosure by Provider/Subcontractor and Provider/Subcontractor's employees, by Provider/Subcontractor's corporate affiliates and their employees, and by Provider/Subcontractor's subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 U.S.C. § 654(26); 42 C.F.R. Part 431, Subpart F; and 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subparts A and E. To the extent that Provider/Subcontractor, in the course of performing under the terms of the Agreement, serves as a business associate of Company and/or HFS, as "business associate" is defined in the HIPAA Privacy Rule (45 C.F.R. § 160.103), Provider/Subcontractor shall assist Company and/or HFS in responding to the client as provided in the HIPAA Privacy Rule, and shall maintain for a period of six (6) years any records relevant to an individual's eligibility for services under the HFS Medical Program. [ICP Contract § 9.1.21; FHP-ACA Contract § 9.1.21]

d. Provider/Subcontractor, to which Company provides Enrollee PHI that Company has received from HFS or created or received by Company on behalf of HFS, agrees to the same restrictions and conditions that apply under the terms of the State Contracts to Company with respect to such information. [ICP Contract, Attachment VI § C.5; FHP-ACA Contract, Attachment VI § C.5]

18. Medical Records. With respect to Enrollee medical records:

a. In addition to the requirements set forth in the Agreement, Provider/Subcontractor shall maintain Enrollee medical records in a timely, legible, accurate, current, complete, and organized manner, with appropriate dates and identification and initialing/signature of the Provider/Subcontractor, to facilitate retrieval and compilation of records, to ensure Enrollee continuity of care, and to permit effective and confidential patient care and quality review. For each encounter or episode of care that Provider/Subcontractor has with an Enrollee, Provider/Subcontractor shall place the following information into the Enrollee's medical records: (1) the reason for the encounter; (2) evidence of the Provider/Subcontractor's assessment of the Enrollee's health problems; (3) current diagnosis of the Enrollee, including the results of any diagnostic tests; (4) the plan of treatment, including any therapies and health education; (5) any medical history relevant to the current episode of care; and (6) confirmation that all outcomes of ancillary reports, such as laboratory tests and x-rays, have been reviewed by the individual or entity who ordered the reports and that follow-up actions have been taken regarding report results that are deemed significant by the individual or entity who ordered those reports. [77 Ill. Admin. Code §§ 240.50(c)(1), 240.90(a)–(b); ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

b. Provider/Subcontractor shall ensure that Enrollee medical records contain documented efforts to obtain Enrollee consent when required by law. Provider/Subcontractor shall furthermore only release Enrollee medical records to Authorized Persons, or to any primary care provider (PCP), women's health care provider (WHCP), or other Provider of Enrollee (subject to Enrollee's consent when required by law), and shall only release original Enrollee medical records in accordance with federal or State law, court orders, subpoenas, or a valid records-release form executed by the Enrollee. Provider/Subcontractor shall protect the confidentiality and privacy of minors, and shall abide by all federal and State laws regarding the confidentiality and disclosure of medical records, mental health records, and any other information about Enrollees. Provider/Subcontractor shall produce Enrollee medical records to HFS upon request. [ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

c. If Provider/Subcontractor is an Enrollee's primary care provider (PCP), Provider/Subcontractor shall furthermore maintain a permanent medical record for that Enrollee to ensure continuity of care. The medical record for each Enrollee who has had a routine, scheduled appointment with his/her primary care provider (PCP) shall include the following information: (1) identification; (2) patient history; (3) known past surgical procedures; (4) known past and current diagnoses and problems; and (5) known allergies and untoward reactions to drugs. [77 Ill. Admin. Code § 240.90(c); ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

d. If Enrollee changes PCPs or "medical homes," Provider/Subcontractor shall forward Enrollee's medical records or copies thereof to the new PCP or "medical home" promptly upon Enrollee's transfer. [ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

e. Provider/Subcontractor shall only record diagnosis codes in Enrollee's medical records at the time of creation of that medical record, and shall not retroactively adjust any such diagnosis codes except to correct errors. [ICP Contract § 7.4.1; FHP-ACA Contract § 7.4.1]

19. Use of Hospitalists. Neither Company nor Provider/Subcontractor shall require or otherwise mandate, whether by contract, written policy, or procedure, any Enrollee to substitute his or her participating primary care provider (PCP) during inpatient hospitalization, such as with a hospitalist physician, without the agreement of that Enrollee's participating primary care provider (PCP). Company and Provider/Subcontractor (if applicable) shall inform Enrollees of any policies, recommendations, or guidelines concerning the substitution of the Enrollee's primary care provider (PCP) when hospitalization is necessary in the manner set forth in 215 ILCS 5/15(d)–(e). [215 ILCS 134/30(c)]

20. Provider Enrollment, Credentialing, Licensure, and Privileges.

a. Provider/Subcontractor shall be enrolled as a provider in the HFS Medical Program (as defined below), if such enrollment is required by HFS's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. Provider/Subcontractor shall not, in turn, contract or subcontract with an individual or entity that has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement. For purposes of this provision, the term "HFS Medical Program" means the (i) Illinois Medical Assistance Program administered under Article V of the Illinois Public Aid Code (305 ILCS 5/5-1 *et seq.*) or its successor program, and Titles XIX (42 U.S.C. § 1396 *et seq.*) and XXI (42 U.S.C. § 1397aa *et seq.*) of the Social Security Act, and Section 12-4.35 of the Illinois Public Aid Code (305 ILCS 5/12-4.35); and (ii) the State Children's Health Insurance Program administered under 215 ILCS 106 and Title XXI of the Social Security Act (42 U.S.C. § 1397aa *et seq.*). [ICP Contract §§ 1.71, 5.28.4; FHP-ACA Contract §§ 1.75, 5.28.4]

b. Provider shall comply with all credentialing and recredentialing policies and procedures that Company implements to verify Provider's credentials, including without limitation by completing a credentialing application in accordance with applicable policies and procedures. Furthermore, Provider shall comply with all applicable credentialing/recredentialing standards and requirements set forth in the State Contracts and in applicable federal and State laws, regulations, and written policies. [ICP Contract § 5.7.1, Attachment XI ¶ 8; FHP-ACA Contract § 5.8.1, Attachment XI ¶ 8]

c. If Provider/Subcontractor operates a laboratory testing site that provides services to Enrollees, (i) that site shall possess a valid Clinical Laboratory Improvement Amendment (CLIA) certificate and comply with the CLIA regulations found at 42 C.F.R. Part 493, and (ii) Provider/Subcontractor shall report lab values to Company directly. [ICP Contract §§ 5.19.2, 5.28.9.4; FHP-ACA Contract §§ 5.19.2, 5.28.9.4]

d. If Provider is a physician, such physician Provider shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is also a participating Provider with Company; or, in lieu of these admitting and/or delivery privileges, such physician Provider shall have a written referral agreement with a separate physician who is a participating Provider with Company and who has such privileges at a hospital that is also a participating Provider with Company. Such physician Provider shall coordinate care with the referring physician and shall ensure that Enrollee medical records are appropriately transferred; the physicians' written referral agreement shall contain appropriate provisions that document and require such coordination of care and transfer of medical records. [ICP Contract § 5.28.1.2; FHP-ACA Contract § 5.28.1.2]

e. If Provider/Subcontractor provides long-term care and HCBS services under the Agreement, Provider/Subcontractor shall be approved and authorized by the State to provide such Covered Services, and shall only provide to Enrollees those particular Covered Services for which they are approved and authorized. [FHP-ACA Contract § 5.8.5]

21. Disclosure of Ownership and Control; Prohibited Relationships; Background Checks.

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in federal health care programs, or is 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, Provider/Subcontractor shall disclose to Company: any required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest information; and information on any criminal convictions regarding Provider/Subcontractor and any owner(s) and managing employee(s) at the time the Agreement is executed and annually thereafter, and any time there are changes to such information. [ICP Contract § 9.2.34; FHP-ACA Contract § 9.2.34]

b. No Provider/Subcontractor, no individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider/Subcontractor, and no officer, director, agent, or managing employee (*i.e.*, general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over that Provider/Subcontractor or who directly or indirectly conducts the day-to-day operation of that Provider/Subcontractor) shall be an entity or individual: (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)–(3) of the Social Security Act (42 U.S.C. § 1320a-7(b)(1)–(3)); (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a State health care program. [ICP Contract § 9.2.34; FHP-ACA Contract § 9.2.34]

c. Provider/Subcontractor shall not be an Excluded Person (as that term is defined below), and shall not employ, subcontract with, or affiliate with an Excluded Person. The term "Excluded Person" means any individual or entity that (i) under Section 1128 of the Social Security Act, is or has been terminated, barred, suspended, or otherwise excluded from participation in, or as the result of a settlement agreement has voluntarily withdrawn from participation in, any program under federal law, including any program under Titles IV, XVIII, XIX, XX or XXI of the Social Security Act; (ii) has not been reinstated in the program after a period of exclusion, suspension, debarment, or ineligibility; or (iii) has been convicted of a criminal offense related to the provision of items or services to a federal, state, or local government entity within the last ten (10) years. Provider/Subcontractor acknowledges and agrees that under the State Contracts, Company must terminate its relationship with Provider/Subcontractor immediately upon learning that such Provider/Subcontractor meets the definition of an Excluded Person, and must notify the HFS OIG of the termination. [ICP Contract §§ 5.22, 9.1.32; FHP-ACA Contract §§ 5.22, 9.1.32]

d. Provider/Subcontractor acknowledges and agrees that prior to entering into the Agreement, Company may be required to submit a disclosure statement to HFS identifying any agreements, Providers, and/or Subcontractors in which any of the following have a financial interest of five percent (5%) or more: (a) any individual or entity also having a financial interest of five percent (5%) or more in Company or Company's affiliates as defined by 42 C.F.R. § 455.101; (b) any director, officer, trustee, partner, or employee of Company or Company's Affiliates; and (c) any member of the immediate family of any individual or entity designated above. [ICP Contract § 5.28.12; FHP-ACA Contract § 5.28.12]

e. Provider/Subcontractor acknowledges and agrees that the State may conduct, at the State's expense and whenever the State deems it reasonably necessary for security reasons, criminal and driver history background checks of Provider/Subcontractor and its officers, employees, or agents, and furthermore acknowledges and agrees that Provider/Subcontractor shall immediately reassign any such individual who, in the opinion of the State, does not pass the background checks. [ICP Contract § 9.1.13; FHP-ACA Contract § 9.1.13]

22. Fraud, Abuse and Misconduct. Provider/Subcontractor shall report immediately in writing to Company and to the HFS OIG any suspected fraud, abuse, or misconduct associated with any service or function provided for under the Agreement and/or the State Contracts by any parties directly or indirectly affiliated with the Agreement and/or the State Contracts, including without limitation Company and Company's staff, Provider/Subcontractor and its employees and subcontractors, and HFS employees or contractors. Provider/Subcontractor shall make this report to Company and to the HFS OIG within three (3) days after first suspecting fraud, abuse, or misconduct. Provider/Subcontractor shall not conduct any investigation of the suspected fraud, abuse, or misconduct without the express concurrence of the HFS OIG; the foregoing notwithstanding, Provider/Subcontractor may conduct and continue investigations necessary to determine whether reporting is required under this provision. Provider/Subcontractor must report the results of such an investigation to the HFS OIG as described above. Provider/Subcontractor shall cooperate with all investigations of suspected fraud, abuse, or misconduct reported pursuant to this provision. Nothing in this provision precludes Company or Provider/Subcontractor from establishing measures to maintain quality of services and control costs that are consistent with their usual business practices, from conducting themselves in accordance with their respective legal

or contractual obligations, or from taking internal personnel-related actions. [ICP Contract §§ 5.31.1, 9.1.29; FHP-ACA Contract §§ 5.31.1, 9.1.29]

23. Offshore Services. Provider/Subcontractor is prohibited from using any individual or entity (an "Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative, or other individual or entity) to perform any services in connection with the State Contracts 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/Subcontractor further agrees that Company has the right to audit any Offshore Entity prior to the provision of any Offshore Services. Provider/Subcontractor further represents and warrants that it does not and will not permit any Enrollees' protected health information (PHI) or other personal information to be accessible by any Offshore Entity, without prior written notice to Company and Company's prior written approval of such Offshore Entity. In the event that Company agrees in advance and in writing to permit Provider/Subcontractor to use an Offshore Entity to perform any services in connection with the State Contracts and Company agrees that such Offshore Entity will receive, process, transfer, handle, store, or access Enrollee PHI as defined at 45 C.F.R. § 160.103, Provider/Subcontractor agrees that Offshore Services that involve Enrollee PHI are subject to CMS reporting within thirty (30) days of: (a) performing, or contracting with an Offshore Entity to perform, Offshore Services, and (b) any time Provider/Subcontractor changes the Offshore Services that an Offshore Entity will perform.

24. Business Enterprise Program (BEP) Registration. In the event that Provider/Subcontractor is a minority-owned business, a female-owned business, or a business owned by persons with disabilities, then Provider/Subcontractor shall seek and obtain State certification as a Business Enterprise Program (BEP) vendor under the Business Enterprise Program Act for Minorities, Females and Persons with Disabilities. Provider/Subcontractor shall furthermore cooperate with Company with respect to Company's obligations under the State Contract related to the Business Enterprise Program (BEP) and shall, among other things, maintain a record of all relevant data with respect to the utilization of BEP-certified individuals and entities, including, but not limited to, payroll records, invoices, canceled checks, and books of account, for a period of at least five (5) years after the completion of the Agreement. [ICP Contract §§ 2.92, 7.16.2; FHP-ACA Contract §§ 2.92, 7.16.2]

25. Marketing Activities. Provider/Subcontractor shall not engage in any inappropriate or unallowable marketing activities and practices as set forth in the State Contracts and 42 C.F.R. § 438.104, and shall submit to Company for its review any marketing or information materials of Provider/Subcontractor that relate to the State Contracts, prior to disseminating same. Provider/Subcontractor furthermore shall not induce any employees of the State to improperly reveal any confidential information regarding Enrollees or otherwise use such confidential information in a fraudulent manner. [ICP Contract § 4.16.3; FHP-ACA Contract § 4.16.3]

26. Compliance with Laws, the State Contracts, and Company Policies and Procedures.

a. Provider/Subcontractor shall perform all services and other duties under the Agreement in accordance and compliance with, and subject to, all applicable federal, State, and local laws, rules, ordinances, regulations, orders, federal circulars, and license and permit requirements in the performance of the Agreement, including without limitation, the Managed Care Reform and Patient Rights Act (215 ILCS 134/ 1 *et seq.*), the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by the Illinois Department of Financial and Professional Regulation, the Illinois Department of Public Health, and/or federal CMS. Company shall be in compliance with applicable tax requirements and shall be current in payment of such taxes. Company shall obtain at its own expense all licenses and permissions necessary for the performance of the Agreement. [ICP Contract §§ 2.2, 2.5, 9.1.12; FHP-ACA Contract §§ 2.2, 2.5, 9.1.12]

b. Provider/Subcontractor shall be bound by the terms and conditions of the State Contracts that are appropriate to the services provided by, or activities delegated to, Provider/Subcontractor in connection with the State Contracts. These terms and conditions include, without limitation, the record-keeping and audit provisions of the State Contracts, such that the Authorized Persons shall have the same rights to audit and inspect Provider/Subcontractor (and any downstream providers or subcontractors

thereof) as they have to audit and inspect Company. [ICP Contract § 5.28.1.1; FHP-ACA Contract § 5.28.1.1]

c. Provider/Subcontractor shall comply with the prior-authorization requirements and processes set forth in Company's policies and procedures. [ICP Contract §§ 5.16.5, 5.16.6; FHP-ACA Contract § 5.16.5, 5.16.6]

d. Provider/Subcontractor shall comply with all utilization-management and peer-review programs, processes, and timeframes established by Company. [ICP Contract, Attachment XII ¶ 4; FHP-ACA Contract, Attachment XII ¶ 4]

27. State Employee Handbook. If Provider/Subcontractor or any of its employees and subcontractors provide services under the Agreement at a location controlled by HFS or any other State agency, Provider/Subcontractor shall abide by all applicable provisions of the controlling State agency's Employee Handbook. [ICP Contract § 9.1.27; FHP-ACA Contract § 9.1.27]

28. Prohibition on Gifts. Provider/Subcontractor and its principals, employees, and subcontractors are prohibited from giving gifts to HFS employees, and from giving gifts to, or accepting gifts from, any individual or entity that has a contemporaneous contract with HFS involving duties or obligations related to the Agreement and/or the State Contracts. [ICP Contract § 9.1.30; FHP-ACA Contract § 9.1.30]

29. No Transfer of Liability to Providers. Neither Company nor Subcontractor shall transfer or attempt to transfer to any health care provider, by indemnification, hold harmless, or contribution requirements that are set forth in any contract, written policy, or procedure, any liability relating to activities, actions, or omissions of Company and/or Subcontractor or their respective officers, employees, or agents; provided, however that nothing in this provision shall relieve any health care provider from liability for his, her, or its own negligence in the performance of his, her, or its duties arising from treatment of an Enrollee. [215 ILCS 134/95]

30. Capitated Contracts. If Company compensates Provider/Subcontractor under the Agreement on a capitated basis for furnishing, arranging, or providing health care services:

a. Provider/Subcontractor agrees that in no event, including but not limited to nonpayment by Company of amounts due to Provider/Subcontractor under the Agreement, insolvency of Company, or any breach of the Agreement by Company, shall Provider/Subcontractor or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Enrollee or persons acting on the Enrollee's behalf (other than Company) for services provided pursuant to the Agreement, except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Enrollees and persons acting on the Enrollees' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider/Subcontractor and the Enrollee or persons acting on the Enrollee's behalf (other than Company). [50 Ill. Admin. Code § 5241.50(e)]

b. Provider/Subcontractor shall submit timely encounter data/records for all Covered Services that it has provided to Enrollees, in the format specified by the State, so that Company can meet the encounter-reporting specifications and requirements set forth in the State Contracts. Provider/Subcontractor shall be responsible for transmitting all data to Company as required by 42 C.F.R. § 438. [ICP Contract § 7.11.3; FHP-ACA Contract §§ 5.6.6, 7.11.3]

c. If Provider/Subcontractor is a "Managed Care Organization" as that term is defined in 50 Ill. Admin. Code § 5241.20, Provider/Subcontractor shall submit to Company copies of Provider/Subcontractor's quarterly financial statements, which shall include Provider/Subcontractor's balance sheet and statements of income and cash flow within forty-five (45) days after the end of each fiscal period. In addition, Provider/Subcontractor shall submit, within ninety (90) days after the end of Provider/Subcontractor's fiscal year, copies of Provider/Subcontractor's audited annual financial

statements prepared in accordance with generally accepted accounting principles, if available. Provider/Subcontractor acknowledges and agrees that HFS, at its discretion, may require Company to submit for HFS's inspection the financial statements that Company has received from Provider/Subcontractor (which such financial statements shall be deemed confidential by HFS). Provider/Subcontractor agrees to fully cooperate with, and disclose all relevant information requested by, Company's actuaries for the preparation of such actuaries' opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16. Company acknowledges that in the event of Provider/Subcontractor's insolvency, Company is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Company's Enrollees. [50 Ill. Admin Code §5241.50(d)] For purposes of this provision, "Managed Care Organization" or "MCO" means a partnership, association, corporation, or other legal entity, including but not limited to individual practice associations (IPAs) and physician hospital organizations (PHOs), that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services. [50 Ill. Admin. Code § 5241.20]

31. Required Certifications of Provider/Subcontractor. Provider/Subcontractor acknowledges and agrees that its compliance with Section 9.2 of each of the State Contracts and each subsection of Section 9.2 (collectively, the "Standard Certifications") is a material requirement and condition of this Agreement during the entire term thereof, including during any renewal periods. By executing the Agreement, Provider/Subcontractor certifies compliance with the Standard Certifications in their entirety, and Provider/Subcontractor is under a continuing obligation to remain in compliance with, and to report any non-compliance with respect to, the Standard Certifications. Furthermore, Provider/Subcontractor shall include the Standard Certifications in any subcontracts or other contracts with its downstream entities or related entities that Provider/Subcontractor enters into in connection with the State Contracts. During the term of the State Contracts, Provider/Subcontractor shall confirm compliance with the Standard Certifications in the manner and format determined by the State by the date specified by the State, and in no event later than July 1 of each year that the State Contracts remains in effect. As part of each Standard Certification, Provider/Subcontractor acknowledges and agrees that if Provider/Subcontractor or its subcontractors, downstream entities, or related entities provide false information, or fail to be or remain in compliance with the Standard Certifications, one or more of the following sanctions will apply: (a) the Agreement may be void by operation of law; (b) the State may void the Agreement; and (c) Provider/Subcontractor and its subcontractors, downstream entities, or related entities may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty. [ICP Contract § 9.2.1; FHP-ACA Contract § 9.2.1]

The Standard Certifications are set forth below:

a. Provider/Subcontractor certifies it and its employees will comply with applicable provisions of the United States Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101, *et seq.*), and applicable rules in the performance of this Agreement. [ICP Contract § 9.2.2; FHP-ACA Contract § 9.2.2]

b. Provider/Subcontractor certifies, if applicable, that it is not in default on an educational loan (5 ILCS 385/3). This applies to individuals, sole proprietorships, partnerships, and individuals as members of LLCs. [ICP Contract § 9.2.3; FHP-ACA Contract § 9.2.3]

c. Provider/Subcontractor (if an individual, sole proprietor, partner, or an individual as member of an LLC) certifies, if applicable, that it has not received (i) an early retirement incentive prior to 1993 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133.3, or (ii) an early retirement incentive on or after 2002 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133 (30 ILCS 105/15a). [ICP Contract § 9.2.4; FHP-ACA Contract § 9.2.4]

d. Provider/Subcontractor certifies, if applicable, that it is a properly formed and existing legal entity (30 ILCS 500/1.15.80, 20-43), and as applicable has obtained an assumed name certificate from the appropriate authority, or has registered to conduct business in Illinois and is in good standing with the Illinois Secretary of State. [ICP Contract § 9.2.5; FHP-ACA Contract § 9.2.5]

e. Provider/Subcontractor certifies that it has neither been convicted of bribing or attempting to bribe an officer or employee of the State or any other state, nor made an admission of guilt of such conduct that is a matter of record (30 ILCS 500/50-5). [ICP Contract § 9.2.7; FHP-ACA Contract § 9.2.7]

f. If Provider/Subcontractor has been convicted of a felony, Provider/Subcontractor certifies at least five (5) years have passed after the date of completion of the sentence for such felony, unless no person held responsible by a prosecutor's office for the facts upon which the conviction was based continues to have any involvement with the business (30 ILCS 500/50-10). [ICP Contract § 9.2.8; FHP-ACA Contract § 9.2.8]

g. If Provider/Subcontractor, or any officer, director, partner, or other managerial agent of Provider/Subcontractor, has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law of 1953, Provider/Subcontractor certifies that at least five (5) years have passed since the date of the conviction. Provider/Subcontractor further certifies that it is not barred from being awarded a contract and acknowledges that the State shall declare the Agreement void if this certification is false (30 ILCS 500/50-10.5). [ICP Contract § 9.2.9; FHP-ACA Contract § 9.2.9]

h. Provider/Subcontractor certifies that it is not barred from having a contract with the State based on violating the prohibition on providing assistance to the State in identifying a need for a contract (except as part of a public request for information process) or by reviewing, drafting, or preparing a solicitation or similar documents for the State (30 ILCS 500/50-10.5e). [ICP Contract § 9.2.10; FHP-ACA Contract § 9.2.10]

i. Provider/Subcontractor certifies that it and its affiliates are not delinquent in the payment of any debt to the State (or if delinquent has entered into a deferred payment plan to pay the debt), and Provider/Subcontractor and its affiliates acknowledge that the State may declare the Agreement void if this certification is false (30 ILCS 500/50-11) or if Provider/Subcontractor or an affiliate later becomes delinquent and has not entered into a deferred payment plan to pay off the debt (30 ILCS 500/50-60). [ICP Contract § 9.2.11; FHP-ACA Contract § 9.2.11]

j. Provider/Subcontractor certifies that it and its affiliates shall collect and remit Illinois Use Tax on all sales of tangible personal property into the State in accordance with provisions of the Illinois Use Tax Act (30 ILCS 500/50-12) and acknowledges that failure to comply can result in the Agreement being declared void. [ICP Contract § 9.2.12; FHP-ACA Contract § 9.2.12]

k. Provider/Subcontractor certifies that it has not been found by a court or the Pollution Control Board to have committed a willful or knowing violation of the Environmental Protection Act within the last five (5) years, and is therefore not barred from being awarded a contract (30 ILCS 500/50-14). [ICP Contract § 9.2.13; FHP-ACA Contract § 9.2.13]

l. Provider/Subcontractor certifies that it has not paid any money or valuable thing to induce any person to refrain from bidding on a State contract, nor has Provider/Subcontractor accepted any money or other valuable thing, or acted upon the promise of same, for not bidding on a State contract (30 ILCS 500/50-25). [ICP Contract § 9.2.14; FHP-ACA Contract § 9.2.14]

m. Provider/Subcontractor certifies that it is not in violation of the "Revolving Door" section of the Illinois Procurement Code (30 ILCS 500/50-30). [ICP Contract § 9.2.15; FHP-ACA Contract § 9.2.15]

n. Provider/Subcontractor certifies that it has not retained a person to attempt to influence the outcome of a procurement decision for compensation contingent in whole or in part upon the decision or procurement (30 ILCS 500/50-38). [ICP Contract § 9.2.16; FHP-ACA Contract § 9.2.16]

o. Provider/Subcontractor certifies that it will report to the Illinois Attorney General and the Chief Procurement Officer any suspected collusion or other anti-competitive practice among any bidders,

offerors, contractors, proposers, or employees of the State (30 ILCS 500/50-40, 50-45, 50-50). [ICP Contract § 9.2.17; FHP-ACA Contract § 9.2.17]

p. In accordance with the Steel Products Procurement Act, Provider/Subcontractor certifies that steel products used or supplied in the performance of a contract for public works shall be manufactured or produced in the United States, unless the executive head of the procuring agency grants an exception (30 ILCS 565). [ICP Contract § 9.2.18; FHP-ACA Contract § 9.2.18]

q. If Provider/Subcontractor employs twenty-five (25) or more employees, Provider/Subcontractor certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580). [ICP Contract § 9.2.19; FHP-ACA Contract § 9.2.19]

r. Provider/Subcontractor certifies that neither Provider/Subcontractor nor any substantially owned affiliate of Provider/Subcontractor is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce (30 ILCS 582). [ICP Contract § 9.2.20; FHP-ACA Contract § 9.2.20]

s. Provider/Subcontractor certifies that it has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33E-3, E-4). [ICP Contract § 9.2.21; FHP-ACA Contract § 9.2.21]

t. Provider/Subcontractor certifies that it complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105). [ICP Contract § 9.2.22; FHP-ACA Contract § 9.2.22]

u. Provider/Subcontractor certifies that it does not pay dues to or reimburse or subsidize payments by its employees for any dues or fees to any "discriminatory club" (775 ILCS 25/2). [ICP Contract § 9.2.23; FHP-ACA Contract § 9.2.23]

v. Provider/Subcontractor certifies that it complies with the State Prohibition of Goods from Forced Labor Act, and certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Agreement have been or will be produced in whole or in part by forced labor, or indentured labor under penal sanction (30 ILCS 583). [ICP Contract § 9.2.24; FHP-ACA Contract § 9.2.24]

w. Provider/Subcontractor certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Agreement have been produced in whole or in part by the labor or any child under the age of twelve (30 ILCS 584). [ICP Contract § 9.2.25; FHP-ACA Contract § 9.2.25]

x. Provider/Subcontractor certifies that it is not in violation of Section 50-14.5 of the Illinois Procurement Code (30 ILCS 500/50-14.5), which states: "Owners of residential buildings who have committed a willful or knowing violation of the Lead Poisoning Prevention Act (410 ILCS 45) are prohibited from doing business with the State until the violation is mitigated." [ICP Contract § 9.2.26; FHP-ACA Contract § 9.2.26]

y. Provider/Subcontractor warrants and certifies that it and, to the best of its knowledge, its subcontractors, downstream entities, or related entities, have and will comply with Executive Order No. 1 (2007). That Order generally prohibits contractors and subcontractors from hiring the then-serving Illinois Governor's family members to lobby procurement activities of the State, or any other unit of government in the State including local governments if that procurement may result in a contract valued at over $25,000. This prohibition also applies to hiring for that same purpose any former State employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity. [ICP Contract § 9.2.27; FHP-ACA Contract § 9.2.27]

z. Provider/Subcontractor certifies that information technology, including electronic information, software, systems, and equipment developed or provided under the Agreement will comply

with the applicable requirements of the Illinois Information Technology Accessibility Act Standards as published at www.dhs.state.il.us/iitaa (30 ILCS 587). [ICP Contract § 9.2.28; FHP-ACA Contract § 9.2.28]

aa. Provider/Subcontractor certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal or State department or agency, and is not currently barred or suspended from contracting with the State under Section 50-35(f), 50-35(g) or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 *et seq.* If at any time during the term of the Agreement, Provider/Subcontractor becomes barred, suspended, or excluded from participation in this transaction, Provider/Subcontractor shall, within thirty (30) days after becoming barred, suspended, or excluded, provide to HFS a written description of each offense causing the exclusion, the date(s) of the offense(s), the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence completed. [ICP Contract § 9.2.29; FHP-ACA Contract § 9.2.29]

bb. Provider/Subcontractor certifies that neither Provider/Subcontractor, nor any party directly or indirectly affiliated with Provider/Subcontractor, including but not limited to Provider/Subcontractor's officers, directors, employees, and subcontractors, and the officers, directors, and employees of Provider/Subcontractor's subcontractors, shall have or acquire any Conflict of Interest (as defined below) in performance of the Agreement. Provider/Subcontractor shall disclose in writing any Conflicts of Interest to HFS no later than seven (7) days after learning of the Conflict of Interest. HFS may initiate any inquiry as to the existence of a Conflict of Interest, and Provider/Subcontractor shall cooperate with all such inquiries. HFS shall determine, in its sole discretion, whether a Conflict of Interest exists or whether Provider/Subcontractor failed to make any required disclosure. If HFS concludes that a Conflict of Interest exists, or that Provider/Subcontractor failed to disclose any Conflict of Interest, HFS may impose one or more remedies in its sole discretion, including without limitation the elimination of the Conflict of Interest or the non-renewal or termination of the Agreement. [ICP Contract § 9.2.30; FHP-ACA Contract § 9.2.30]

i. For purposes of this provision, "Conflict of Interest" shall mean an interest of Provider/Subcontractor, or any entity described above, which may be direct or indirect, professional, personal, financial, or beneficial in nature that, in the sole discretion of HFS, compromises, appears to compromise, or gives the appearance of impropriety with regard to Provider/Subcontractor's duties and responsibilities under the Agreement. This term shall include potential Conflicts of Interest. A Conflict of Interest may exist even if no unethical or improper act results from it or may arise where Provider/Subcontractor becomes a party to any litigation, investigation, or transaction that materially impacts Provider/Subcontractor's ability to perform under the Agreement. Any situation where Provider/Subcontractor's role under the Agreement competes with Provider/Subcontractor's professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable individual, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur, or that gives the appearance of the existence of bias or improper conduct, is a Conflict of Interest. [ICP Contract § 9.2.30.1; FHP-ACA Contract § 9.2.30.1]

cc. Provider/Subcontractor certifies that it is in compliance with all applicable standards, orders, or regulations issued pursuant to the federal Clean Air Act (42 U.S.C. § 7401 *et seq.*) and the federal Water Pollution Control Act (33 U.S.C. § 1251 *et seq.*). Violations shall be reported to the United States Department of Health and Human Services and the appropriate Regional Office of the United States Environmental Protection Agency. [ICP Contract § 9.2.31; FHP-ACA Contract § 9.2.31]

dd. Provider/Subcontractor certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of Provider/Subcontractor, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If any funds other than federally appropriated funds have been paid

or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, Provider/Subcontractor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such form is to be obtained at Provider/Subcontractor's request from the HFS Bureau of Fiscal Operations. Provider/Subcontractor shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when the Agreement was executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure. [ICP Contract § 9.2.32; FHP-ACA Contract § 9.2.32]

ee. Provider/Subcontractor certifies that it has read, understands, and is in compliance with the registration requirements of the Elections Code (10 ILCS 5/9-35) and the restrictions on making political contributions and related requirements of the Illinois Procurement Code (30 ILCS 500/20-160 and 50-37). Provider/Subcontractor will not make a political contribution that will violate these requirements, which are effective for the duration of the term of office of the incumbent State governor or for a period of two (2) years after the end of the Agreement's term, whichever is longer. Provider/Subcontractor will certify, as applicable, either that it is not required to register as a business entity with the State Board of Elections, or has registered with the State Board of Elections and will appropriately and timely update that registration. [ICP Contract § 9.2.33 & Attachment X; FHP-ACA Contract § 9.2.33 & Attachment X]

ADDENDUM B

Regulatory Compliance Addendum
Governing Medicare-Medicaid Dual-Eligible Services
(Aetna Better Health of Illinois)

This Regulatory Compliance Addendum Governing Medicare-Medicaid Dual-Eligible Services (the "Duals Addendum") shall govern the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the *Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services, In Partnership with the State of Illinois Department of Healthcare and Family Services and Aetna Better Health Inc.*, issued on November 1, 2013 (the "Three-Way Contract"), which established and governs the program known as the Illinois Medicare-Medicaid Alignment Initiative a/k/a the MMAI (the "MMAI") and under which Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois ("Company") serves as a managed care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and/or the MMAI.

This Duals Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing the Agreement, as identified on the first page of the Agreement (the "Provider"), and Provider must comply with the requirements set forth herein. Note that this Duals Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement, in the Three-Way Contract, and in the policies, procedures, and provider manual of Company (or its Affiliate, as the case may be). This Duals Addendum and the Agreement may be revised as directed by the State of Illinois and/or by the Centers for Medicare and Medicaid Services.

For purposes of this Duals Addendum, Company may be referred to as "MCO" or "the MCO" (a/k/a managed care organization), and the individuals who are enrolled with Company under the MMAI may be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Duals Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Duals Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Duals Addendum will govern and control with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and/or the MMAI; provided, however, that if there is any conflict between any of the terms of this Agreement, including this Duals Addendum, and the Three-Way Contract, then the terms of the Three-Way Contract will govern and control. Except as provided herein, all other provisions of the Agreement not inconsistent with this Duals Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Duals Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Three-Way Contract and the remainder of the Agreement.

Provider acknowledges and agrees that all provisions of this Duals Addendum shall apply equally to any employees, independent contractors, subcontractors, downstream entities, or related entities of Provider that provide Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, or that provide administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and/or the MMAI, and Provider represents and warrants that Provider shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Duals Addendum and all applicable laws and regulations.

REQUIREMENTS FOR THE MMAI

A. Illinois State Requirements

The State of Illinois requires that specific terms and conditions be incorporated into the Agreement. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the following

requirements with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract and the MMAI:

1. Hold Harmless of Enrollees. Provider agrees that in no event, including but not limited to the nonpayment by Company of amounts due to Provider under the Agreement, the insolvency of Company, or any breach of the Agreement by Company, shall Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against the Member or persons acting on the Member's behalf (other than Company) for services provided pursuant to the Agreement except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Members and all persons acting on the Members' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf (other than Company). [215 ILCS 125/2-8(a)]

2. Quality Assurance. Provider shall provide, arrange for, or participate in the quality-assurance programs mandated by the Illinois Health Maintenance Organization Act, unless the Illinois Department of Public Health has certified that such programs will be fully implemented without any participation or action from Provider. [215 ILCS 125/2-8(a); 50 Ill. Admin. Code § 5241.50(a)(4)]

3. Termination of Agreement. Notwithstanding anything in the Agreement to the contrary, if either Company or Provider seeks (i) to terminate the Agreement "with cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least sixty (60) days' written notice to the other party; or (ii) to terminate the Agreement "without cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least ninety (90) days' written notice to the other party. Furthermore, Provider shall cooperate with Company with respect to Company's obligation to provide timely notice to Enrollees of any termination that would curtail or eliminate services to such Enrollees, with such notice to be sent (i) at least sixty (60) days prior to that termination, or (ii) immediately, if Company receives less than sixty (60) days' notice of that termination from Provider. The notice to be sent to Enrollees shall include instructions regarding referrals that have previously been issued and appointments that may be pending. [50 Ill. Admin. Code § 5241.50(a)(5)–(6); 305 ILCS 5/5F-40(a)]

4. No Discrimination. Provider will not discriminate against Enrollees or potential Enrollees on the basis of payment source. [77 Ill. Admin. Code § 240.50(d)(4)]

5. Anti-Gag Clause; Prohibition on Retaliation. Provider shall not be prohibited or otherwise restricted or discouraged from, and shall not prohibit or otherwise restrict or discourage its downstream providers or subcontractors from, taking any of the following actions so long as those actions are within the lawful scope of the acting party's practice: (a) advocating for medically appropriate health care services for Enrollees, which may include without limitation appealing denials and protesting decisions, policies, and practices; and/or (b) discussing with Enrollees, prospective Enrollees, or the public any health care services, health care providers, utilization review policies, quality assurance policies, or terms and conditions of plans and plan policy. Furthermore, Company shall not retaliate against Provider, and Provider shall not retaliate against its downstream providers or subcontractors, for any of the foregoing actions. Notwithstanding the foregoing, nothing in this provision shall be construed to prohibit: (a) Company or Provider from making a determination not to pay for a particular health care service, from enforcing reasonable peer review or utilization review protocols, or from determining whether a physician or other health care provider has complied with those protocols; and/or (b) a Provider that is a hospital from taking disciplinary actions against a physician as authorized by law. [215 ILCS 134/30(a); 215 ILCS 134/35(a)–(d)]

6. Cooperation with Company. Provider shall cooperate with Company with respect to Company's obligations and responsibilities relating to the "HMO self-evaluation structure" and associated activities set forth in 77 Ill. Admin. Code § 240.60. [77 Ill. Admin. Code § 240.50(d)(1)(C)]

7. Pharmacy Benefits. Company and Provider shall not permit or allow, whether by contract, written policy, or procedure, any individual or entity to dispense a different drug in place of the drug or brand of drug

ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act (codified at 410 ILCS 620/3.14). [215 ILCS 134/30(b)]

8. Use of Hospitalists. Neither Company nor Provider shall require or otherwise mandate, whether by contract, written policy, or procedure, any Enrollee to substitute his or her participating primary care provider (PCP) during inpatient hospitalization, such as with a hospitalist physician, without the agreement of that Enrollee's participating primary care provider (PCP). Company and Provider (if applicable) shall inform Enrollees of any policies, recommendations, or guidelines concerning the substitution of the Enrollee's primary care provider (PCP) when hospitalization is necessary in the manner set forth in 215 ILCS 5/15(d)–(e). [215 ILCS 134/30(c)]

9. No Transfer of Liability to Downstream Providers. Neither Company nor Provider shall transfer or attempt to transfer to any health care provider, by indemnification, hold harmless, or contribution requirements that are set forth in any contract, written policy, or procedure, any liability relating to activities, actions, or omissions of Company and/or Provider or their respective officers, employees, or agents; provided, however that nothing in this provision shall relieve any health care provider from liability for his, her, or its own negligence in the performance of his, her, or its duties arising from treatment of an Enrollee. [215 ILCS 134/95]

10. Medical Records. With respect to Enrollee medical records:

a. Provider shall maintain Enrollee medical records in a timely, legible, accurate, current, complete, and organized manner, with appropriate dates and identification and initialing/signature of the Provider, to facilitate retrieval and compilation of records and to ensure Enrollee continuity of care. For each encounter or episode of care that Provider has with an Enrollee, Provider shall place the following information into the Enrollee's medical records: (1) the reason for the encounter; (2) evidence of the Provider's assessment of the Enrollee's health problems; (3) current diagnosis of the Enrollee, including the results of any diagnostic tests; (4) the plan of treatment, including any therapies and health education; (5) any medical history relevant to the current episode of care; and (6) confirmation that all outcomes of ancillary reports, such as laboratory tests and x-rays, have been reviewed by the individual or entity who ordered the reports and that follow-up actions have been taken regarding report results that are deemed significant by the individual or entity who ordered those reports. [77 Ill. Admin. Code §§ 240.50(c)(1), 240.90(a)–(b)]

b. If Provider is an Enrollee's primary care provider (PCP), Provider shall furthermore maintain an Enrollee medical record that contains, with respect to each routine, scheduled appointment with that primary care provider (PCP): (1) identification; (2) patient history; (3) known past surgical procedures; (4) known past and current diagnoses and problems; and (5) known allergies and untoward reactions to drugs. [77 Ill. Admin. Code § 240.90(c)]

11. Capitated Contracts. If Company compensates Provider under the Agreement on a capitated basis for furnishing, arranging, or providing health care services:

a. Provider agrees that in no event, including but not limited to nonpayment by Company of amounts due to Provider under the Agreement, insolvency of Company, or any breach of the Agreement by Company, shall Provider or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Member or persons acting on the Member's behalf (other than Company) for services provided pursuant to the Agreement, except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Members and persons acting on the Members' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf (other than Company). [50 Ill. Admin. Code § 5241.50(e)]

b. If Provider is a "Managed Care Organization" as that term is defined in 50 Ill. Admin. Code § 5241.20, Provider shall submit to Company copies of Provider's quarterly financial statements, which shall include Provider's balance sheet and statements of income and cash flow within forty-five (45) days after the end of each fiscal period. In addition, Provider shall submit, within ninety (90) days after the end of Provider's fiscal year, copies of Provider's audited annual financial statements prepared in accordance with generally accepted accounting principles, if available. Provider acknowledges and agrees that the Illinois Department for Healthcare and Family Services ("HFS"), at its discretion, may require Company to submit for HFS's inspection the financial statements that Company has received from Provider (which such financial statements shall be deemed confidential by HFS). Provider agrees to fully cooperate with, and disclose all relevant information requested by, Company's actuaries for the preparation of such actuaries' opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16. Company acknowledges that in the event of Provider's insolvency, Company is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Company's Enrollees. [50 Ill. Admin Code §5241.50(d)] For purposes of this provision, "Managed Care Organization" or "MCO" means a partnership, association, corporation, or other legal entity, including but not limited to individual practice associations (IPAs) and physician hospital organizations (PHOs), that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services. [50 Ill. Admin. Code § 5241.20]

B. Medicare Requirements

Without limiting any obligation of Provider under the Agreement, Provider shall comply with, and shall cause its Downstream Entities and Related Entities to comply with, the requirements set forth in this **Section B** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider), as applicable, that relate to those Covered Services or to the Three-Way Contract and the MMAI (the "Medicare Services"). (The terms "Downstream Entities" and "Related Entities" shall have the respective meanings that are ascribed to them in **Schedule 1** hereto, and shall include Provider's permanent and temporary employees.) For purposes of this **Section B**, the Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI shall collectively be referred to as the "Medicare Members," and the managed-care plan that MCO offers under the Three-Way Contract and the MMAI shall be referred to as the "Medicare Plan." Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. 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 Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement).

B. MCO shall not pay any amounts beyond the amounts set forth in the applicable Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement), 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 MCO 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, MCO's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. MCO 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 adjust payments to Provider for Covered Services until the earlier of (i) the discontinuation of the Medicare Payment Adjustment, or (ii) the replacement of the Medicare Payment Adjustment by a subsequent Medicare Payment Adjustment.

C. Pursuant to Section B.5.K. of this Duals Addendum, Provider certifies that the diagnosis codes submitted to MCO for Medicare Members that MCO is required to submit to CMS will be accurate, complete, and truthful (the "**Certification**"). Provider acknowledges and agrees that MCO may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to MCO 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, "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 (the "**Medicare Statute of Limitations**"). If MCO makes an overpayment or payment in error to Provider for Medicare Members, MCO 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 MCO's reasonable suspicion of fraud or other intentional misconduct.

E. In no event, including without limitation non-payment by MCO, insolvency of MCO, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Medicare Member or persons (other than MCO) acting on a Medicare Member's behalf for services covered under the Agreement. Provider further agrees that: (i) this provision shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Medicare Members, and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Medicare Member or persons acting on a Medicare Member's behalf. No modification of this provision shall be effective without the prior written approval of the appropriate regulatory entities.

2. ASSIGNMENT. In addition to all other rights of MCO under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Duals Addendum) may be assigned by MCO, at any time and from time to time, in whole or in part, to any other affiliate or successor in interest of MCO. At MCO's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with MCO for those products/lines of business designated by MCO 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, MCO shall provide advance written notice to Provider. In the event of a conflict between this Section and any other provision of the Agreement, the terms of this Section shall supersede and prevail.

3. EFFECT OF TERMINATION. In the event this Duals Addendum is terminated for any reason, such termination shall not constitute termination of any of MCO's other products, plans, or programs.

4. MEDICARE REQUIRED PROVISIONS. Provider agrees to comply with all of the provisions of the Schedules attached hereto and incorporated into this Duals Addendum (including **Schedule 1** and any delegated function-specific Schedules that may be appended hereto), and agrees that all terms and conditions in the Agreement applicable to Provider shall also apply to any Downstream Entities of Provider. Provider further acknowledges and agrees that all terms of such Schedules shall apply equally to services provided in connection with the Three-Way Contract and the MMAI, even if such Schedules only refer to Medicare Advantage products. Provider acknowledges that to the extent MCO is delegating to Provider any activities and responsibilities in connection with the Three-Way Contract and the MMAI, MCO may only delegate such activities and responsibilities in a manner consistent with the contractual and legal obligations and duties imposed on MCO under the Three-Way Contract and under applicable Medicare laws, regulations, rules, and other directions of CMS.

5. 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. Compliance; Cooperation. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement will be consistent and comply with MCO's obligations under the Three-Way Contract. Upon request, Provider shall immediately provide to MCO any information that is required by MCO 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 MCO that MCO, 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 MCO 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 MCO for the Medicare Plan from CMS pursuant to the Three-Way Contract, as well as payments that Provider receives from MCO for performing services and functions under the Agreement, constitutes the receipt of federal funds. As a result, Provider, by entering into this Agreement and the terms of this Duals 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 the Three-Way Contract terminates or MCO becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized 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 Duals Addendum, regardless of the reason for termination, including the insolvency of MCO, and shall supersede any oral or written agreement between Provider and a Medicare Member.

E. Policies, Programs & Procedures. Provider agrees to comply with MCO's policies and procedures (which MCO shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Duals Addendum, and the Three-Way Contract and MMAI. Provider agrees to comply with MCO's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies MCO may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that an MCO 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, on behalf of itself and its Downstream Entities (if any), shall preserve records applicable to Medicare Members or to MCO's participation in the Three-Way Contract and MMAI, 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 42 C.F.R. § 423.2480(c) and to maintain all records containing data used by MCO to calculate Medicare medical loss ratios ("MLRs") for MCO's Medicare products and/or evidence needed by MCO 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 MCO to CMS. Provider further agrees that with respect to Medicare Plans, MCO and federal governmental authorities having jurisdiction, and their designees, upon request, shall have access to all MLR Records, and that this right of inspection, evaluation, and audit of MLR Records shall continue for a minimum of ten (10) years

from the date such MLRs were reported by MCO to CMS. This provision shall survive the termination of the Agreement, regardless of the cause of termination.

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 (a) all of the contractual and legal obligations and duties imposed on Provider in the Agreement, (b) all provisions required under Medicare laws, regulations, rules, and other directions of CMS (including all of MCO's obligations under such laws, regulations, rules, and other directions related to the scope of Provider's services under the Agreement), and (c) that any delegated services or activities to be performed by subcontractor shall be consistent and comply with the obligations in the Three-Way Contract. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly. Provider acknowledges that, with respect to any services or functions under the Agreement that Provider delegates to a subcontractor, such subcontractor shall be considered a Downstream Entity.

(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 MCO delegates to Provider the selection of providers, MCO retains the right to approve, suspend or terminate such delegation. If MCO delegates the selection of providers, MCO will either review the credentials of medical professionals affiliated with Provider or MCO 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 and/or 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 shall not employ or contract with, with or without compensation, any individual or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in a federal health care program. 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. Furthermore, neither Provider nor any of Provider's Downstream Entities who are and/or will be fully or partially responsible for Provider's performance of its obligations under the Agreement has (i) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; (ii) been excluded from participation in any federal or state funded health program; or (iii) been listed in the Department of Health and Human Services Office of Inspector ("OIG") exclusion list or the General Services Administrative ("GSA") exclusion list. Provider agrees to immediately notify MCO in the event that Provider or any of its Downstream Entities that assist or are involved in Provider's performance of services for Medicare Plans under the Agreement are or become disbarred, excluded, suspended, or otherwise determined to be ineligible to participate in a federal health care program. 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, the "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 the Medicare Plan, 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 Duals Addendum, MCO shall have the right, in its sole discretion and judgment, to terminate this Duals 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 (an "Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative, or other individual or entity) to perform any services for the Medicare Plan 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 MCO, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that MCO has the right to audit any Offshore Entity prior to the provision of Offshore Services for the Medicare Plan. Provider further represents and warrants that it does not and will not permit any Medicare Members' protected health information (PHI) or other personal information to be accessible by any Offshore Entity, without prior written notice to MCO and MCO's prior written approval of such Offshore Entity. In the event that MCO agrees in advance and in writing to permit Provider to use an Offshore Entity to perform any services for Medicare Plans and MCO agrees that such Offshore Entity will receive, process, transfer, handle, store, or access Medicare Member PHI as defined at 45 C.F.R. § 160.103, Provider agrees that Offshore Services that involve Medicare Member 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 MCO 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 MCO and to provide MCO with all such information in such form and manner as requested by MCO. Provider agrees to immediately notify MCO if any encounter data that Provider submitted to MCO for Medicare Members is inaccurate, incomplete, or erroneous, and to cooperate with MCO to correct erroneous encounter data to ensure MCO's compliance with Medicare laws, rules and regulations and CMS instructions.

K. Certification of Data. Provider recognizes that MCO 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 MCO by its contractors and subcontractors. Provider and its subcontractors, if any, hereby certify that any such data submitted to MCO will be accurate, complete, and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by MCO.

L. Medicare Member Complaints. Provider agrees to cooperate with MCO in resolving any Medicare Member complaints related to coverage or the provision of Covered Services. MCO 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 MCO 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 Downstream Entities, if any, 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 the Medicare Plan. Such compliance program shall

be appropriate to the organization and operations of Provider and Provider's Downstream Entities and shall include:

(1) written compliance policies and standards of conduct that are comparable to Aetna's compliance policies/Aetna Code of Conduct and articulate the entity's commitment to comply with federal and state laws, ethical behavior, and compliance program operations. Provider will disseminate either Aetna's compliance policies/Aetna Code of Conduct or comparable versions to Provider's employees, officers, and Downstream Entities within 90 days of hire/contracting, when updates are made, and annually thereafter;

(2) reporting mechanisms communicated to Provider's employees and Downstream Entities for their use in adhering to the expectation that Provider, its employees, and its Downstream Entities report potential non-compliance or FWA issues (internally and to MCO, as applicable) and understand their obligation to report. Provider must publicize the reporting methods to Provider employees and Downstream Entities along with a no-tolerance policy for retaliation or retribution for good-faith reporting;

(3) completion of CMS's Medicare Learning Network® (MLN) "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training" by Provider employees, officers, and Downstream Entities initially within ninety (90) days of hire/contracting and at least annually thereafter, unless exempt from such training under relevant CMS regulations;

(4) processes to oversee and ensure that Provider and Provider's Downstream Entities maintain compliance with processes to oversee and ensure that: (1) Provider and Provider's Downstream Entities maintain compliance with CMS compliance program requirements, and (2) Provider's Downstream Entities perform Medicare Services consistent with this Agreement and the agreement between Provider and such Downstream Entities. Provider's oversight under this Agreement shall include: (1) imposition of disciplinary actions, as needed, to ensure employee compliance with CMS compliance program requirements, and (2) implementation of corrective actions (up to and including contract termination), as needed, with respect to its Downstream Entities to ensure Downstream Entity compliance with applicable CMS requirements, including the CMS compliance program requirements, this Agreement, and Provider's contract with the Downstream Entity; and

(5) retention of evidence showing that Provider and Provider's Downstream Entities complied with the requirements set forth in this Section. Such evidence must be maintained for at least the period of time specified in Section B.5.F. hereof and shall be made available to MCO and CMS, upon request.

N. Marketing. Consistent with federal laws, regulations, and agency requirements applicable to the Medicare program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare Members, 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 are not responsible for paying to Provider any Copayments, Coinsurance, or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when, as applicable, either the State Medicaid plan or MCO (as the State's managed-care organization) is responsible for such Cost Sharing Amounts. Provider further agrees that it will not collect Cost Sharing Amounts from Medicare Members when, as applicable, either the State Medicaid plan or MCO (as the State's managed-care organization) is responsible for such Cost Sharing Amounts, and will instead accept the responsible party's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts.

P. Enrollment as Medicare Provider. To the extent that Provider prescribes drugs covered

under Medicare Part D to Medicare Members who have Medicare prescription drug ("MA-PD") coverage offered by MCO, Provider agrees to comply with the requirements set forth in 42 C.F.R. § 423.120(c)(6), including without limitation the requirement that Provider be enrolled in Medicare in an approved status in order for its prescriptions to be covered under Medicare Part D.

Q. Home Infusion Drugs. The following provisions shall only apply to Provider if Provider dispenses to a Medicare Member home infusion drugs that are covered under Medicare Part D and the Medicare Member has MA-PD coverage offered by MCO ("Home Infusion Drug"):

1. With respect to Home Infusion Drugs, MCO will pay clean claims (as defined in 42 C.F.R. § 423.520(b)) submitted by Provider on behalf of Medicare Members within 14 days for electronic claims and within 30 days for claims submitted otherwise. 42 C.F.R. § 423.505(i)(3)(vi).

2. Home Infusion Drugs will be reimbursed (as applicable) in accordance with a fee schedule, or the third-party pricing source (*e.g.,* Medi-Span) otherwise agreed upon as set forth in this Agreement or Provider's agreement with MCO's Pharmacy Benefit Manager ("PBM"). 42 C.F.R. § 423.505(i)(3)(viii)(B).

3. If a prescription drug pricing standard is used for reimbursement of Home Infusion Drugs, updates to such a standard will occur not less frequently than once every 7 days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the Home Infusion Drug. 42 CFR § 423.505(i)(3)(viii)(A).

4. In accordance 42 C.F.R.§ 423.120(c)(3), Provider agrees to submit claims for Home Infusion Drugs to MCO or its PBM whenever the Medicare Member's ID card is presented or is on file at the Provider, unless the Medicare Member expressly requests that the claim not be submitted to MCO or its PBM.

5. Provider must submit claims for Home Infusion Drugs in real time by means of point of service claims adjudication systems in compliance with CMS standards. 42 C.F.R. § 423.505(b)(17).

6. Provider must provide Medicare Members with access to the negotiated prices (as defined in 42 C.F.R. § 423.100) for Home Infusion Drugs to Members. 42 C.F.R. § 423.104(g)(1).

7. Provider must charge/apply the correct cost-sharing amount to the Medicare Member for Home Infusion Drugs. 42 C.F.R. § 423.104.

8. At the time of purchase by a Medicare Member, Provider must inform the Medicare Member of any differential between the price of the Home Infusion Drug being dispensed and the price of the lowest priced generic version of that Home Infusion Drug available from Provider, unless the Home Infusion Drug being dispensed is the lowest priced generic version of that Home Infusion Drug. 42 C.F.R. § 423.132.

9. Provider agrees to ensure that the professional services and ancillary supplies necessary for Home Infusion Drugs are in place before dispensing Home Infusion Drugs to a Medicare Member in his/her place of residence. 42 C.F.R. § 423.120(a)(4)(iii).

10. Provider agrees to provide delivery of Home Infusion Drugs within 24 hours of a Medicare Member's discharge from an acute setting, or later if so prescribed. 42 C.F.R. § 423.120(a)(4)(iv).

11. Provider shall submit to MCO (not PBM) claims for equipment, supplies, and professional services associated with Home Infusion Drugs dispensed by Provider to a Medicare

Member that are covered under Medicare Part C.

R. Non-Covered Services. Provider shall not hold a Member financially responsible for payment of a service not covered under the Member's Plan ("Non-Covered Service") unless the Member has received a pre-service organization determination notice of denial from MCO before such services are rendered. Provider acknowledges and agrees that if Provider renders Non-Covered Services to a Member who has not received a pre-service organization determination notice of denial from MCO, the Provider must hold the Member harmless for the Non-Covered Services and cannot charge the Member any amount beyond the normal cost-sharing amounts (*i.e.*, copayments, coinsurance, and/or deductibles). With respect to those Non-Covered Services that are clearly listed as exclusions in the Member's Evidence of Coverage or other similar Plan document, a pre-service organization determination is not required in order for Provider to hold the Member financially liable for such Non-Covered Services.

6. COMPANY OBLIGATIONS.

A. Fee Schedule. MCO shall arrange for Provider to be compensated for health care services rendered to Medicare Members in accordance with Section B.1 of this Duals Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(a)(1), MCO 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 Duals Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. § 422.500.

C. From time to time MCO may designate only certain Providers to take part in the provider delivery network for a particular product benefit plan(s).

7. GENERAL PROVISIONS.

A. Termination. This Duals 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 and the Three-Way Contract. This Duals Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement and the Three-Way Contract.

B. Governing Law. This Duals Addendum shall be governed by federal laws, regulations, and agency requirements applicable to the Medicare program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare program occur, the new law, regulation, or agency requirement shall supersede to the extent required by any such later required changes.

C. Agreement Otherwise Unmodified. 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 Duals Addendum and the Agreement, the terms of this Duals Addendum shall govern and control.

D. Survival. All provisions of this Duals Addendum that 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.

C. Requirements Under the MMAI Three-Way Contract

The Three-Way Contract requires that specific additional terms and conditions be incorporated into the Agreement. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the requirements set forth in this **Section C** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract and the MMAI. With respect to the requirements set forth

in this **Section C**, any capitalized terms that are used but not defined herein shall have the meanings that are ascribed to them in the Three-Way Contract. Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. The delegated activities and reporting requirements for which Provider is responsible are contained in the Agreement. Provider shall ensure that it and its downstream and related entities perform all such delegated activities and reporting requirements in compliance with 42 C.F.R. §§ 422.504, 423.505, 438.6(l), and 438.230(b)(1), as applicable. [Appendix C, ¶ A of Three-Way Contract]

2. HHS, the Comptroller General, the State of Illinois Department of Healthcare and Family Services (the "Department"), the Department's Office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, and their designees, and other state and federal agencies with monitoring authority related to Medicare and Medicaid, have the right to audit, evaluate, and inspect any books, contracts, computer, or other electronic systems, including medical records and documentation, of Provider and its downstream and related entities, and the foregoing rights to inspect, evaluate, and audit any pertinent information for any particular contract period shall exist for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later. [Appendix C, ¶ B of Three-Way Contract]

3. Provider and its downstream and related entities shall not hold Enrollees liable for payment of any fees that are the obligation of MCO. [Appendix C, ¶ C.1 of Three-Way Contract]

4. Any services or other activity performed by Provider and/or its downstream and related entities shall be performed in accordance with the MCO's contractual obligations to CMS and the Department. [Appendix C, ¶ C.2 of Three-Way Contract]

5. MCO shall revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS, the Department, or the MCO determine that Provider and/or its downstream and related entities have not performed their delegated activities or reporting requirements satisfactorily. [Appendix C, ¶ C.4 of Three-Way Contract]

6. The performance of Provider and its downstream and related entities under the Agreement will be monitored by MCO on an ongoing basis and MCO may impose corrective action as necessary. [Appendix C, ¶ C.5 of Three-Way Contract]

7. Provider and its downstream and related entities agree to safeguard Enrollee privacy and confidentiality of Enrollee health records. [Appendix C, ¶ C.6 of Three-Way Contract]

8. Provider and its downstream and related entities must comply with all federal and state laws, regulations, and CMS instructions. [Appendix C, ¶ C.7 of Three-Way Contract]

9. To the extent that Provider and/or its downstream and related entities provide credentialing of medical providers under the Agreement:

   A. The credentials of medical professionals affiliated with the Provider and/or its downstream and related entities will be reviewed by MCO; or

   B. The credentialing process will be reviewed and approved by MCO and MCO shall audit the credentialing process on an ongoing basis.

[Appendix C, ¶ D of Three-Way Contract]

10. To the extent that MCO has delegated the selection of providers under the Agreement to Provider or its downstream and related entities, MCO retains the right to approve, suspend, or terminate that arrangement. [Appendix C, ¶ E of Three-Way Contract]

11. MCO has the right to terminate its contract with Provider with cause upon sixty (60) days' notice,

and without cause upon 120 days' notice, and Provider shall assist with transitioning Enrollees to new providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the MCO or Enrollee. If a for-cause termination, MCO must have an internal grievance procedure that allows Provider to contest the grounds for the termination prior to the effective date of the termination. [Appendix C, ¶ F of Three-Way Contract]

12. MCO shall provide a written statement to Provider of the reason or reasons for termination for cause. [Appendix C, ¶ G of Three-Way Contract]

13. MCO is obligated to pay Provider under the terms of the Agreement, which includes a prompt-payment provision that has been developed and agreed to by both MCO and Provider. [Appendix C, ¶ H.1 of Three-Way Contract]

14. Provider and its downstream and related entities shall provide all services under the Agreement in a Culturally Competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds. [Appendix C, ¶ H.2 of Three-Way Contract]

15. Provider and its downstream and related entities shall abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. [Appendix C, ¶ H.3 of Three-Way Contract]

16. Provider and its downstream and related entities shall ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas. [Appendix C, ¶ H.4 of Three-Way Contract]

17. Provider and its downstream and related entities shall maintain Enrollee records and information in an accurate and timely manner. [Appendix C, ¶ H.5 of Three-Way Contract]

18. Provider and its downstream and related entities shall ensure timely access by Enrollees to the records and information that pertain to them. [Appendix C, ¶ H.6 of Three-Way Contract]

19. Provider and its downstream and related entities shall not hold Enrollees liable for Medicare Part A and B cost sharing, and all Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees. [Appendix C, ¶ H.7 of Three-Way Contract]

20. Provider and its downstream and related entities shall ensure that their EMTALA obligations are fulfilled as required by law and the Agreement and must not create any conflicts with any hospital actions required to comply with EMTALA. [Appendix C, ¶ H.8 and Section 2.9.9.1 of Three-Way Contract]

21. Provider and its downstream and related entities, including without limitation all primary care providers, shall not close or otherwise limit acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees. [Appendix C, ¶ H.9 of Three-Way Contract]

22. MCO shall not refuse to contract or pay Provider for the provision of Covered Services solely because Provider has in good faith:

(a) Communicated with or advocated on behalf of one or more of the prospective, current, or former patients of Provider or its downstream and related entities regarding the provisions, terms, or requirements of the MCO's health benefit plans as they relate to the needs of such patients; or

(b) Communicated with one or more of the prospective, current, or former patients of Provider or its downstream and related entities with respect to the method by which such provider is compensated by the MCO for services provided to the patient.

[Appendix C, ¶ H.10 of Three-Way Contract]

23. Provider and its downstream and related entities are not required to indemnify MCO for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against MCO based on MCO's management decisions, utilization review provisions, or other policies, guidelines, or actions. [Appendix C, ¶ H.11 of Three-Way Contract]

24. Provider and its downstream and related entities shall comply with all MCO's requirements and MCO Policies for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services. [Appendix C, ¶ H.12 of Three-Way Contract]

25. MCO shall notify Provider in writing of modifications in payments, modifications in Covered Services or modifications in MCO's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 30 calendar days before the effective date of such modification unless such other date for notice is mutually agreed upon between MCO and Provider or unless such change is mandated by CMS or the Department without 30 calendar days' prior notice. [Appendix C, ¶ H.13 of Three-Way Contract]

26. Provider must comply with all Enrollee payment restrictions, including balance billing restrictions, and MCO may revoke or impose other specified remedies against Provider if Provider does not comply with such provisions. [Appendix C, ¶ H.14 of Three-Way Contract]

27. Provider and its downstream and related entities shall not bill Enrollees for charges for Covered Services other than pharmacy co-payments, if applicable. [Appendix C, ¶ H.15 of Three-Way Contract]

28. No payment shall be made by MCO to Provider, and Provider shall not seek payment from MCO, for a Provider Preventable Condition as defined in 42 C.F.R. § 447.26(b), and Provider shall, as a condition of payment from MCO, comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by MCO and/or the Department. [Section 2.7.3.2 and Appendix C, ¶¶ H.16 and H.17 of Three-Way Contract]

29. To the extent Provider is a Primary Care Physician or a specialty provider, Provider shall ensure coverage for its practice twenty-four (24) hours a day, seven (7) days a week and have a published after-hours telephone number; voicemail alone after hours is not acceptable. [Section 2.9.2.1 and 2.10.4.1 of Three-Way Contract]

30. MCO shall monitor and ensure that all Utilization Management activities provided by Provider comply with all provisions of the Three-Way Contract, and Provider and its downstream and related entities shall cooperate with and utilize MCO's quality assurance program. [Section 2.13.2.1.2.2 and Appendix C, ¶ H.18 of Three-Way Contract]

31. Provider shall not bill Enrollees for missed appointments or refuse to provide services to Enrollees who have missed appointments. Providers must work with Enrollees and MCO to assist Enrollees in keeping their appointments. [Appendix C, ¶ H.19 of Three-Way Contract]

32. Provider shall not refuse to provide services to an Enrollee because the Enrollee has an outstanding debt with the Provider from a time prior to the Enrollee becoming a member. [Appendix C, ¶ H.20 of Three-Way Contract]

33. Provider shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. Contracts or arrangements with First Tier, Downstream and Related Entities shall not include incentive plans that include a specific payment to Provider or its downstream and related entities as an inducement to deny, reduce, delay, or limit specific, Medically Necessary Services, and (a) Provider and/or its downstream and related entities shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate, and (b) MCO shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically

appropriate. Nothing herein shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared-risk agreements that are made with respect to physicians or physician groups or that are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services, and equipment provided or authorized by another physician or health care provider, comply with Paragraph 34 immediately below. [Appendix C, ¶¶ H.14 and I, and Section 5.1.7 of Three-Way Contract]

34. MCO shall not impose a financial risk on Provider or its downstream and related entities for the costs of medical care, services, or equipment provided or authorized by another Physician or health care provider unless such contract includes specific provisions with respect to the following:

A. Stop-loss protection;

B. Minimum patient population size for the Physician or Physician group; and

C. Identification of the healthcare services for which Physician or Physician group is at risk.

[Appendix C, ¶ J of Three-Way Contract]

35. All contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites that provide services must include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. [Appendix C, ¶ K of Three-Way Contract]

36. Nothing shall be construed to restrict or limit the rights of MCO to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious nonmedical providers. [Appendix C, ¶ L of Three-Way Contract]

37. Provider shall meet all terms and requirements of the Three-Way Contract that are applicable to Provider. [Section 2.7.2.2.1 of Three-Way Contract]

38. Provider will collaborate with MCO on documentation systems reporting, communications, policies, and any other matters necessary for any readiness review required under the Three-Way Contract. [Section 2.2.1 of Three-Way Contract]

39. Provider shall collaborate with MCO, as requested and required under the Three-Way Contract, on activities relating to Care Coordination and the Enrollee Care Plans. [Section 2.5 of Three-Way Contract]

40. As requested and required under the Three-Way Contract, Provider shall actively participate as a member of the Interdisciplinary Care Team, and shall collaborate with the Enrollee and other members of the Interdisciplinary Care Team to perform the functions and tasks that are required of the Interdisciplinary Care Team under the Three-Way Contract. [Section 2.5.2 of Three-Way Contract]

41. Provider must maintain locations that are accessible to Enrollees with disabilities and that are ADA compliant. [Section 2.8.1.4 of Three-Way Contract]

42. Provider shall be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollee with disabilities (both congenital and acquired disabilities), or other special population served by the MCO. [Section 2.7.1.6 of Three-Way Contract]

43. To the extent that Provider is multilingual, Provider shall understand and comply with its obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Provider to meet these obligations. [Section 2.7.1.8 of Three-Way Contract]

44. Provider shall maintain a strong understanding of disability culture and Long Term Supports and Services. [Section 2.7.1.14 of Three-Way Contract]

45. To the extent that Provider provides Medicare-covered services, Provider shall be enrolled as a Medicare provider in order to submit claims for reimbursement or otherwise participate in the Medicare program. To the extent that Provider provides Medicaid-covered services, Provider shall be enrolled in the Illinois Medicaid program, if such enrollment is required by the Department's rules or policy, in order to submit claims for reimbursement or otherwise participate in the Illinois Medicaid program. [Section 2.8.1.2 of Three-Way Contract]

46. If a Provider provides any Emergency Services to an Enrollee, the Provider must promptly notify the Enrollee's Primary Care Physician of the Enrollee's screening and treatment. [Section 2.9.8.1.7 of Three-Way Contract]

47. If any Grievance or Appeal is filed with Provider, Provider must immediately forward it to MCO. [Section 2.11.1.1 of Three-Way Contract]

48. Provider must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) as outlined in the Three-Way Contract, and must maintain capacity to deliver services in a manner that reasonably accommodates the needs of Enrollees. [Section 2.9.1.6 of Three-Way Contract]

49. Upon MCO's request, Providers must provide the following information: (a) its name, address, and telephone number; (b) its areas of special experience, skills and training, including any expertise in treating the MMAI population; (c) its office hours, including the name of any provider site open after 5:00 p.m. (Eastern Time) weekdays and/or open on weekends; (d) its cultural and linguistic capabilities, including languages spoken by the Provider or by any skilled medical interpreter at the Provider's site; (e) Provider licensing information; (f) whether it is accessible for people with physical disabilities; (g) whether it is accepting new patients; (h) whether it is accessable by public transportation; and (h) any languages other than English spoken by Provider or by skilled medical interpreters at Provider's site, and whether translation services are available. [Section 2.14.5.2 of Three-Way Contract]

50. As requested and required, Provider must provide any information that CMS and/or the Department require (a) under the Three-Way Contract related to the performance of MCO's responsibilities, including non-medical information for the purposes of research and evaluation; (b) to comply with all applicable federal or state laws and regulations; and (c) for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Grievances and Appeals and enrollment/disenrollment rates. [Section 2.16.1 of Three-Way Contract]

51. Collaborate with MCO in the collection and maintenance of all Encounter Data for all Covered Services that Provider provides to Enrollees, ensuring that all such data can be linked to the Department eligibility data. [Section 2.17 of Three-Way Contract]

52. In connection with the MMAI, Provider shall act in an independent capacity and not as an officer, employee, or agent of the federal government or the State of Illinois. [Section 5.1.3.1 of Three-Way Contract]

53. Provider shall not have any interest that will conflict, as determined by CMS and the Department, with the performance MCO's services under the Three-Way Contract, including without limitation any financial, legal, contractual or other business interest in any entity performing enrollment functions for the Department. [Section 5.3.17 of Three-Way Contract]

54. If requested by the State of Illinois in response to a background check of any officer, employee, or agent of the Provider, the Provider shall immediately reassign any such individual who, in the opinion of the State of Illinois, does not pass the background check. [Section 5.3.21.1 of Three-Way Contract]

55. Provider is prohibited from giving gifts to Department employees, and from giving gifts to, or accepting gifts from, any person who has a contemporaneous contract with the Department involving duties or obligations related to the Three-Way Contract. [Section 5.3.21.8 of the Three-Way Contract]

56. As requested by MCO, Provider shall submit disclosures in accordance with 42 C.F.R. § 455 and 42 C.F.R. § 1002.3. [Section 5.1.6 of Three-Way Contract]

57. Provider shall notify MCO immediately if Provider has lost any required license or state or federal approval, or has been excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 *et seq.* [Sections 2.7.1.3 and 5.3.4 of Three-Way Contract]

58. Provider and its downstream and related entities shall allow MCO to access the medical records of Enrollees, and such access shall include the right to make and/or obtain a copy (in either electronic or hardcopy form) of such records. [Section 2.13.4.2.3 of Three-Way Contract]

59. If the Provider is discharging an Enrollee from a hospital, Provider must assure that the Enrollee receives a written notice of explanation called an "Important Message from Medicare About your Rights" regarding the right to appeal the discharge decision from an inpatient hospital admission. [Section 2.12.7.1 of Three-Way Contract]

60. Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees. [Section 2.8.6 of Three-Way Contract]

61. Provider must be appropriately and continually licensed or certified, as applicable, pursuant to federal and statement requirements. [Section 2.7.2.2.4 of Three-Way Contract]

62. Provider shall conduct all activities in accordance with the Enrollee rights and protections set forth under 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and Appendix B ("Enrollee Rights") of the Three-Way Contract. [Appendix B of Three-Way Contract]

63. Provider may not reuse or provide other entities access to the CMS or Illinois information systems, or data obtained from the CMS or Illinois information systems, to support any line of business other than the MMAI for which the MCO contracted with CMS and the State of Illinois. [Appendix F of Three-Way Contract]

64. Provider acknowledges and agrees that compliance with Sections 5.3.22 through 5.3.32 of the Three-Way Contract and each subsection thereof (collectively, the "**Standard Certifications**") is a material requirement and condition of this Agreement during the entire term thereof, including during any renewal periods. By executing the Agreement, Provider certifies compliance with the Standard Certifications in their entirety, and Provider is under a continuing obligation to remain in compliance with, and to report any non-compliance with respect to, the Standard Certifications. Furthermore, Provider shall include the Standard Certifications in any subcontracts or other contracts with downstream entities or related entities that Provider enters into with respect to the provision of Covered Services to Enrollees dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, including the performance of any activities delegated to Provider in connection with the Three-Way Contract and the MMAI; if the Agreement extends over multiple fiscal years, including the initial term and all renewals, Provider and any such subcontractors, downstream entities, or related entities shall confirm compliance with the Standard Certifications in the manner and format determined by the State of Illinois by the date specified by the State of Illinois, and in no event later than July 1 of each year that the Agreement remains in effect.

If the Parties determine that any Standard Certification is not applicable to the Agreement, such Standard Certification may be stricken without affecting the remaining Standard Certifications.

As part of each Standard Certification, Provider acknowledges and agrees that if Provider or its subcontractors, downstream entities, or related entities provide false information, or fail to be or remain in compliance with the Standard Certifications, one or more of the following sanctions will apply: (a) the Agreement may be void by operation of law; (b) the State of Illinois may void the Agreement; and (c) the Provider and its subcontractors, downstream entities, or related entities may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty. Identifying a sanction or failing to identify a sanction in relation to any of the Standard Certifications does not waive imposition of other sanctions or preclude application of sanctions not specifically identified.

a. Provider certifies it and its employees will comply with applicable provisions of the United States Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101, *et seq.*), and applicable rules in performance of this Agreement.

b. Provider certifies, if applicable, that it is a properly formed and existing legal entity (30 ILCS 500/1.15.80, 20-43); and as applicable has obtained an assumed name certificate from the appropriate authority, or has registered to conduct business in Illinois and is in good standing with the Illinois Secretary of State.

c. Provider certifies it has neither been convicted of bribing or attempting to bribe an officer or employee of the State of Illinois or any other state, nor made an admission of guilt of such conduct that is a matter of record. 30 ILCS 500/50-5.

d. If Provider employs twenty-five (25) or more employees and the Agreement is worth more than $5,000, Provider certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580).

e. Provider certifies that neither Provider nor any substantially owned affiliate of Provider is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce. This applies to contracts that exceed $10,000 (30 ILCS 582).

f. Provider certifies that it has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33E-3, E-4).

g. Provider certifies that it complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105).

h. Provider warrants and certifies that it and, to the best of its knowledge, its subcontractors, downstream entities, or related entities, have and will comply with Executive Order No. 1 (2007). That Order generally prohibits contractors and subcontractors from hiring the then-serving Illinois Governor's family members to lobby procurement activities of the State of Illinois, or any other unit of government in Illinois including local governments if that procurement may result in a contract valued at over $25,000. This prohibition also applies to hiring for that same purpose any former State of Illinois employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity.

i. Provider certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal or state department or agency, and is not currently barred or suspended from contracting with the State of Illinois under Section 50-35(f), 50-35(g) or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 *et seq.* If at any time during the term of this Agreement, Provider becomes barred, suspended, or excluded from participation in this transaction, Provider shall, within thirty (30) days after becoming barred, suspended, or excluded, provide to the Department a written description of each offense causing the exclusion, the date(s) of the offense, the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence complete.

j. Provider certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of

Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Provider shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such form is to be obtained at Provider's request from the Department's Bureau of Fiscal Operations. Provider shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this Agreement was executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

ADDENDUM B — 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 (or its Affiliate, as the case may be) and Provider (referred to in this Schedule 1 as "FDR") not inconsistent herein shall remain in full force and effect. This Amendment 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. Required Provisions:

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's contract with Company (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)]

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:

(i) The delegated activities and reporting responsibilities are specified as follows:

See delegated activities and reporting responsibilities set forth in the Radiology Management Services Agreement, dated January 1, 2014 (as amended).

(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.

See the terms of the Radiology Management Services Agreement, dated January 1, 2014 (as amended), for specific performance-monitoring provisions.

(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.

See the terms of the Radiology Management Services Agreement, dated January 1, 2014 (as amended), for specific credentialing provisions.

(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.

ELEVENTH AMENDMENT TO THE
RADIOLOGY MANAGEMENT SERVICES AGREEMENT

This Amendment ("Amendment") is effective September 26, 2016 and is between Aetna Medicaid Administrators LLC, on behalf of itself and its Affiliates ("Company"); and MedSolutions, Inc. d/b/a eviCore healthcare, on behalf of itself and its affiliates ("Delegated Entity").

WHEREAS, Company and Delegated Entity entered into a Radiology Management Services Agreement on January 1, 2014 ("Agreement") for the provision of Utilization Management services;

WHEREAS, Company and Delegated Entity have since amended the Agreement on or around the following dates: First Amendment on April 1, 2014 (Musculoskeletal Pain Management); Second Amendment on April 1, 2014 (adding Maryland and Pennsylvania Regulatory Addenda); Third Amendment was never executed and is intentionally omitted; Fourth Amendment on July 16, 2014 (adding Missouri and Michigan); Fifth Amendment on May 1, 2015 and re-executed on October 19th, 2015 (adding Louisiana Regulatory Addenda); Sixth Amendment on September 1, 2015 (revising Musculoskeletal Pain Management rates and adding Ohio Regulatory Addendum); Seventh Amendment on December 15, 2015 (restating compensation, updating compliance addenda for Michigan and Louisiana, adding Kentucky and Virginia); Eighth Amendment on February 11, 2016 (restating compensation, adding Missouri for Ultrasound – Non OB for an effective date of October 1, 2015); and Ninth Amendment on April 1, 2016 (adding New Jersey, Texas and Virginia Regulatory Addenda, revising compensation); Tenth Amendment on May 1, 2016 (updating compliance addenda for Illinois); and

WHEREAS, Company and Delegated Entity desire to amend the Agreement to include Coventry Health Care of West Virginia, Inc. d/b/a Aetna Better Health of West Virginia, and Coventry Health Care of Florida, Inc., and update Exhibit 2, Compensation Schedule.

NOW, THEREFORE, in consideration of the mutual covenants and promises stated herein and in the Agreement, and other good and valuable consideration, Company and Delegated Entity agree as follows:

1. The Agreement's Exhibit 2, Compensation Schedule is hereby deleted in its entirety and replaced with the attached Exhibit 2, Compensation Schedule, specifically to add Florida and West Virginia for Advanced Imaging and Pain Management rates.

2. The Agreement's Individual Sites Regulatory Compliance Addendum (Exhibit A) is hereby amended to delete the Regulatory Compliance Addendum Governing Illinois Medicaid Services (Addendum A) and replace it with the attached updated Regulatory Compliance Addendum Governing Illinois Medicaid Services. For avoidance of doubt, the Regulatory Compliance Addendum Governing Medicare-Medicaid Dual-Eligible Services (Aetna Better Health of Illinois), Addendum B, remains unchanged by this Amendment.

3. The Agreement's Individual Sites Regulatory Compliance Addendum (Exhibit A) is hereby amended to add and incorporate in its entirety the attached Florida Medicaid and Florida Health Kids Compliance Addendum – Subcontractor.

4. Delegated Entity shall provide Advanced Imaging and Pain Management services, as set forth on Exhibit 2, Compensation Schedule, in support of the Medicaid and/or CHIP plans and programs that Coventry Health Care of West Virginia, Inc. d/b/a Aetna Better Health of West Virginia offers within the State of West Virginia. The Agreement's Individual Sites Regulatory Compliance Addendum (Exhibit A) is hereby amended to add and incorporate in its entirety the attached Regulatory Compliance Addendum Governing West Virginia Medicaid Services. Delegated Entity agrees to perform its obligations under the Agreement in accordance with the terms and conditions set forth in the aforementioned Regulatory Compliance Addendum to the extent that those terms and conditions are applicable to Delegated Entity's services and obligations under the Agreement. In the event of any conflict between the terms of the attached Regulatory Compliance Addendum, on the one hand, and any of the other terms of the Agreement, on the other hand, including any other attachments, schedules, exhibits, and/or addenda that are currently appended to the Agreement, the terms of the Regulatory Compliance Addendum attached to this Amendment shall govern and control to the extent applicable to Delegated Entity's services and obligations under the Agreement.

5. The Agreement's Exhibit B, Company Affiliates, is hereby deleted in its entirety and replaced with the attached Exhibit B Company Affiliates.

6. All other terms and provisions of the Agreement not amended herein shall remain in full force and effect, without modification.

7. The Parties ratify and affirm the Agreement, and agree that it is in full force and effect as amended herein. In the event of any inconsistency between the terms of this Amendment and the Agreement, the terms of this Amendment shall govern and control.

WITNESS WHEREOF, the Parties have caused this Amendment to be signed by their duly authorized officers as of the date indicated in the introductory clause.

MEDSOLUTIONS, INC.

By: _____

Printed Name Allan D. Feenitske

Title: Chief Accounting & Risk Officer

Date: 9-7-16

AETNA MEDICAID ADMINISTRATORS LLC

By: _____

Printed Name: Robert M. Kessler

Title: Secretary

Date: 9-7-16

Exhibit 2:

COMPENSATION SCHEDULE

This Compensation Schedule shall be governed by and construed in accordance with the terms and conditions of the Radiology Management Services Agreement (the "Agreement") entered into by and between Aetna Medicaid Administrators LLC and Delegated Entity. The rates described in this Exhibit 2 are payable to Affiliate beginning on the Effective Dates listed in the table below. .

Administrative Payment Amount.

The Administrative Fees by member type and modality are listed in the following table.

General Rate Summary.

Modality	TANF	CHIP	ABD	LTSS	Duals	Other	SNP – draft
Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Cardiology	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Ultrasound Ultrasound OB only Ultrasound Non-OB	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

- Advanced Imaging includes management of MRI. MRA, CT, CTA and PET
- Cardiology includes management of Nuclear Cardiology, Heart Cauterization. Stress Echo. TTE, and TEE)
- Ultrasound includes management of OB and non-OB ultrasound, if the plan's TANF ultrasound utilization is below [redacted]

The Administrative Fees by state are listed in the tables below.

State (Effective Date)	Modality	TANF	CHIP	ABD	LTSS	Duals
Arizona (effective 11.01.2014)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Florida (effective 02.27.17)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Illinois (effective 03.09.2015)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Louisiana (effective 10.19.15)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Maryland (effective 04.01.2014)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Ultrasound – Non OB	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Missouri (effective 10.01.2014)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Ultrasound – OB only	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	Ultrasound – Non OB (effective 10.01.2015)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Michigan (effective 11.01.2014)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
New Jersey (effective 07.11.2016)	Advance Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Cardiology	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Ultrasound	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Ohio (effective 03.09.2015)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Ultrasound – Non OB	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Pennsylvania (effective 03.01.2014)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Ultrasound – Non OB	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Texas (effective 09.01.2015)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Ultrasound	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
West Virginia (effective 9.26.2016)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

KENTUCKY AND VIRGINIA HIGH TOUCH ASO PRODUCT

Enhanced Clinical Quality Review

With regard to Kentucky and Virginia. Company and Delegated Entity agree to pursue and implement an enhanced clinical quality review for Advanced Imaging ("Clinical Quality Review Services") for certain Members. The Administrative Fees by Member type and modality are listed in the following table by state:

State (Effective Date)	Modality	TANF	CHIP	ABD	Medicaid Expansion <=18	Medicaid Expansion Adult
Kentucky (effective 02.01.2016)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Ultrasound	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Virginia (effective 04/01/2016)	Advanced Imaging	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Ultrasound	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Pain Management	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

The Clinical Quality Review Services include enhance review of Advance Imaging Prior Authorization requests as follows:

1. Medical Necessity certifications, including alternative recommendations where appropriate, in accordance with evidenced based guidelines and Company's Clinical Policy Bulletin (CPB)

2. At least [redacted] (or as adjusted based on changes in clinical review effectiveness to achieve enhanced compliance with evidence based guidelines, as agreed to by the Parties) of precertification requests shall be subject to Nurse and/or Medical Director review to include determinations for compliance with evidenced based guidelines.

Each month, Delegated Entity shall charge Company an Administrative Fee for the provision of Delegated Entity Program Services. The monthly Administrative Fee shall be equal to the aggregate of the applicable per Member per month amounts set forth in the table below:

1) Payment. On or before the 15th day of each month, Company shall prepay Delegated Entity an "Administrative Fee" for provision of Delegated Entity Program services.

a) If a Member is added to Company Membership on or before the 15th day of a month, a full month's Service Fee will be due for that month. There will be no Administrative Fee due for Members added after the 15th day of the month.

b) A full month's Administrative Fee will be due for the month of termination of a Member if the Member terminates after the 15th day of the month. If a Member terminates on or before the 15th day of a month, no Administrative Fee will be due for the month of termination.

2) Adjustments. Where Company due to information delays, must make a retroactive addition or deletion to Delegated Entity's membership records, a retroactive adjustment shall be made concurrent therewith and such retroactive Administrative Fee adjustments shall not exceed sixty (60) days for each single Member. With the exception of any fraud investigation the limit to the period of time in which Delegated Entity or Company can make a claim of an overpayment or underpayment or contest an underpayment or overpayment under this Agreement is one hundred eighty (180) days from the date of the payment was made or one hundred eighty (180) days from the date of final adjudication.

The Administrative Payment. Amounts otherwise due to Delegated Entity shall be reduced as follows for Delegated Entity's failure to meet the Performance Guarantees set forth in Exhibit 3.

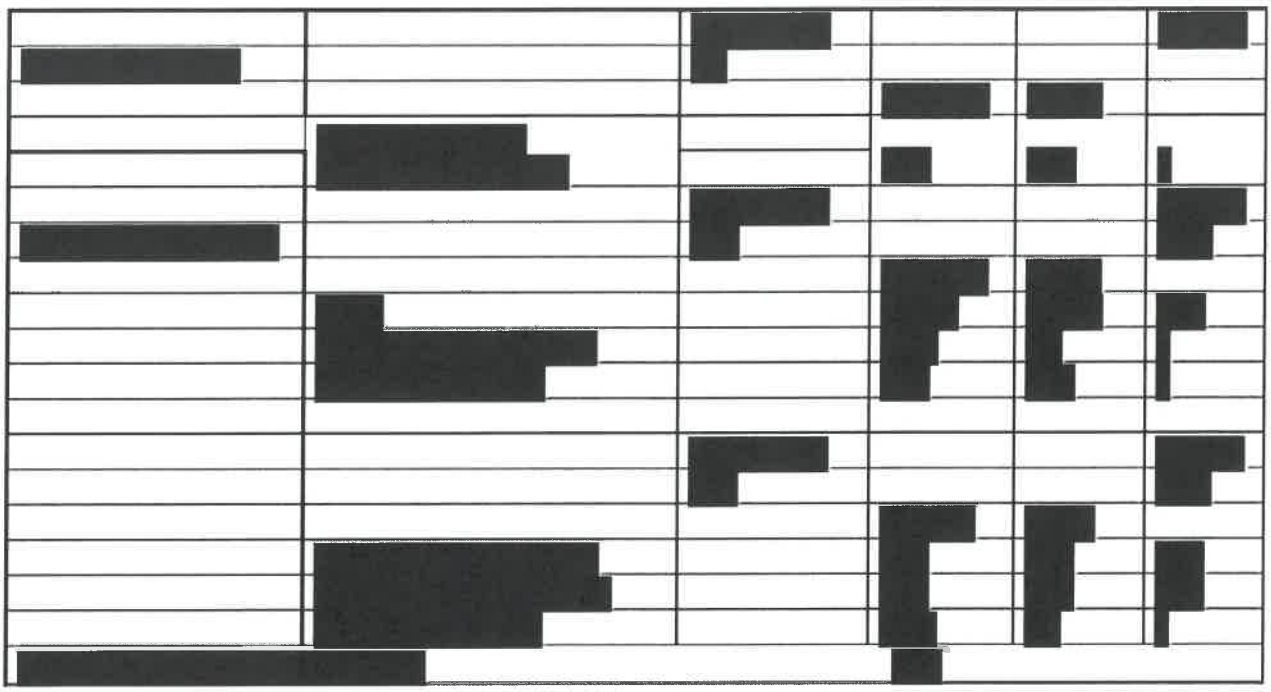
1. For failure to meet any of the satisfaction measures set forth in Exhibit 3, Section B.1 for the previous calendar year, [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous year, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

2. For failure to meet any of the call center measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.2: [redacted] of the annualized Administrative Payment Amounts payable by Company during the previous month, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

3. For failure to meet the pre-certification turn-around-time and Adverse Determination overturn measures when averaged for the calendar year measured as set forth in Exhibit 3, Section B.3: [redacted] of the annualized Administrative Payment Amounts (excluding the Sleep Administrative Services Fee) payable by Company during the previous quarter, regardless of any Performance Credits applied to any portion of the applicable reporting period for failure to meet any other Performance Guarantee.

4. For failure to meet the pre-certification turn-around-time overturn measures for the Sleep Program when averaged for the calendar year measured as set forth in Exhibit 3, Section B.4: [redacted] of the annualized Sleep Administrative Services Fee payable by Company during the previous quarter.

5. Example. Delegated Entity performance results are measured after the Program Year has been completed. Those results become published ninety (90) days at the completion of the Program Year. The results at end of the Program Year show the following:



6. Implementation Costs. Delegated Entity shall pay Company the actual costs incurred by Company, but no more than [redacted], towards Company's implementation costs of the radiology management program ("Implementation Fee"). Delegated Entity shall pay a first installment of [redacted] of the Implementation Fee no later than 15 days after this Agreement's signature. Delegated Entity shall pay second and subsequent installments of the Implementation Fee, if needed, each year thereafter.

Individual Sites Regulatory Addendum – Exhibit A

ADDENDUM A

Regulatory Compliance Addendum
Governing Illinois Medicaid Services

This Regulatory Compliance Addendum Governing Illinois Medicaid Services (the "Illinois Medicaid Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under, as well as the provision of any administrative or health-benefit management services/functions that relate to, as applicable:

(1) the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health Inc., an Illinois Corporation, for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization*, Contract No. 2015-24-004 (ABH) f/k/a Contract No. 2010-24-005-K, effective on or about May 1, 2011, which governs the program known as the Illinois Integrated Care Program a/k/a the ICP (the "ICP Contract");

(2) the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health for Furnishing Health Services by a Managed Care Organization*, Contract No. 2015-24-002, effective on or about August 1, 2014, which governs the program known as the Illinois Family Health Plan Population–Affordable Care Act Adult program a/k/a FHP-ACA program (the "FHP-ACA Contract"); and/or

(3) the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health Inc., an Illinois Corporation for Furnishing Managed Long Term Supports and Services by a Managed Care Organization*, Contract No. 2017-24-002-K, effective on or about July 1, 2016, which governs the program known as the Illinois Managed Long Term Supports and Services a/k/a MLTSS program (the "MLTSS Contract").

Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois ("Company") serves as a managed-care organization under the ICP Contract, the FHP-ACA Contract, and the MLTSS Contract (the "State Contracts") on behalf of the State of Illinois and its Department for Healthcare and Family Services ("HFS" and collectively, the "State").

The State requires that specific terms and conditions be incorporated into the Agreement. As such, this Illinois Medicaid Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof), and such provider, vendor, contractor, or other entity must comply with the requirements set forth herein. Note that this Illinois Medicaid Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in the policies, procedures, and provider manual of Company (or its Affiliate, as the case may be). This Illinois Medicaid Addendum and the Agreement may be revised as directed by the State.

For purposes of this Illinois Medicaid Addendum, the individuals who are enrolled with Company under the State Contracts will be referred to as the "Enrollees." All capitalized terms not defined in this Illinois Medicaid Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Illinois Medicaid Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Illinois Medicaid Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contracts and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contracts. Except as provided herein, all other provisions of the Agreement not inconsistent with this Illinois Medicaid Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Illinois Medicaid Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The provider, vendor, contractor, or other entity identified on the first page of the Agreement acknowledges and agrees that all provisions of this Illinois Medicaid Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members who

are eligible and covered under the State Contracts, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the State Contracts, and it/they represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Illinois Medicaid Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

A. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this Illinois Medicaid Addendum:

a. "Authorized Persons" – Collectively means HFS, HFS's Office of Inspector General ("HFS OIG"), the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, the United States Department of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS"), and any other State or federal agencies with monitoring authority related to Medicaid. [ICP Contract § 1.19; FHP-ACA Contract § 1.20; MLTSS Contract § 1.18]

b. "Provider" – Means any individual or entity that is enrolled with the State to provide Covered Services to Enrollees and that is associated with Company pursuant to a written contract or agreement for the purpose of providing health care services under the State Contracts. [ICP Contract §§ 1.16, 1.118; FHP-ACA Contract §§ 1.16, 1.17, 1.122; MLTSS Contract §§ 1.14, 1.15, 1.125]

c. "Subcontractor" – Means any individual or entity, other than a Provider, with which Company has entered into a written agreement for the purpose of delegating responsibilities applicable to Company under the State Contracts. [ICP Contract § 1.144; FHP-ACA Contract § 1.148; MLTSS Contract § 1.150]

B. Requirements Applicable to State Contracts and Covered Services

1. Practice Coverage and Hours; Enrollee Appointments. Provider agrees to provide Covered Services to Enrollees as set forth in the Agreement, including without limitation the following when such Covered Services are specified in the Agreement:

a. Primary care providers (PCPs) and specialty Providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after-hours telephone number (after-hours voicemail alone is not acceptable). [ICP Contract § 5.6.4; FHP-ACA Contract § 5.7.4]

b. Provider shall offer to Enrollees hours of operation that are no less than the hours of operation offered to persons who are not Enrollees. [ICP Contract § 5.6.3; FHP-ACA Contract § 5.7.3; MLTSS Contract § 5.6.3]

c. Provider shall ensure that time-specific appointments for routine, preventive care to an Enrollee are available within five (5) weeks from the date of request for such care, and within two (2) weeks from the date of request for infants under age six (6) months. If an Enrollee has more serious problems that are not deemed emergency medical conditions, Provider shall triage that Enrollee and, if necessary or appropriate, immediately refer that Enrollee for urgent medically necessary care or provide that Enrollee with an appointment within one (1) business day of the request. If an Enrollee has a problem or complaint that is not deemed serious, Provider shall see that Enrollee within three (3) weeks from the date of request for such care. If Enrollee seeks an initial prenatal visit without expressed problems, the Provider shall see that Enrollee within two (2) weeks after a request if the Enrollee is in her first trimester, within one (1) week if the Enrollee is in her second trimester, and within three (3) days if the Enrollee is in her third trimester. [ICP Contract § 5.6.3; FHP-ACA Contract § 5.7.3; MLTSS Contract § 5.6.3]

2. Payments; Hold Harmless of Enrollees/State.

a. Provider/Subcontractor acknowledges and agrees that Company shall not pay a Provider/Subcontractor for any provider-preventable condition. Provider/Subcontractor shall report all

provider-preventable conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made. [FHP-ACA Contract § 5.25.8; MLTSS Contract § 5.24.8]

b. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state plan or waiver. [42 U.S.C. § 1396a(a)(80); 42 C.F.R. § 438.602(i)]

c. Provider/Subcontractor acknowledges and agrees that upon CMS's implementation of Section 1861(o)(7) of the Social Security Act, Company is prohibited by applicable federal law from making payments for services or items (other than an emergency service or item furnished in an emergency room of a hospital) for home health care services provided by an agency or organization unless that agency or organization has provided the State with a surety bond as specified in Section 1861(o)(7) of the Social Security Act. [MLTSS Contract § 5.5.1.4]

d. Except as permitted or required by HFS in 89 Ill. Adm. Code 125, in HFS's fee-for-service copayment policy in effect at the time Covered Services are provided, and/or in the State Contracts, neither Company nor Provider/Subcontractor may seek or obtain funding through fees or charges to any Enrollee receiving Covered Services under the State Contracts. Provider/Subcontractor furthermore acknowledges and agrees that imposing charges in excess of those permitted under the State Contracts is a violation of Section 1128B(d) of the Social Security Act and subjects the party imposing such charges to criminal penalties. [ICP Contract § 5.30; FHP-ACA Contract § 5.30; MLTSS Contract § 5.29]

e. Provider/Subcontractor agrees that in no event, including but not limited to the nonpayment by Company of amounts due to Provider/Subcontractor under the Agreement, the insolvency of Company, or any breach of the Agreement by Company, shall Provider/Subcontractor or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against the Enrollee or persons acting on the Enrollee's behalf (other than Company) for services provided pursuant to the Agreement except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Enrollees and all persons acting on the Enrollees' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider/Subcontractor and the Enrollee or persons acting on the Enrollee's behalf (other than Company). [215 ILCS 125/2-8(a)]

f. Any dispute between Company and Provider/Subcontractor shall be solely between those parties, and Company and Provider/Subcontractor shall each hold harmless the State and its agencies, officers, employees, agents, and volunteers from and against such dispute and any and all liabilities, demands, claims, suits, losses, damages, causes of action, fines, or judgments, including costs, attorneys' and witnesses' fees, and expenses incident thereto, regardless of the reason. [ICP Contract §§ 7.13, 9.1.8, 9.1.28; FHP-ACA Contract §§ 7.13, 9.1.8, 9.1.28; MLTSS Contract §§ 7.13, 9.1.8, 9.1.28]

3. Standards of Care. In addition to complying with other applicable standards of care, Provider/Subcontractor shall:

a. Timely identify any Enrollees with high-risk pregnancies and arrange for a maternal fetal medicine specialist or a transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements for referral and/or transfer of high-risk women. [ICP Contract, Attachment XXI ¶ 3.c.i.D; FHP-ACA Contract, Attachment XXI ¶ 3.c.i.D; MLTSS Contract, Attachment XXI ¶ 3.c.i.D]

b. Cooperate and communicate with other service providers who serve Enrollees, including without limitation Special Supplemental Nutrition Programs for Women, Infants, and Children (commonly referred to as "WIC" programs); Head Start programs; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the Enrollee). [ICP Contract, Attachment XXI ¶ 3.e.i.; FHP-ACA Contract, Attachment XXI ¶ 3.e.i.; MLTSS Contract, Attachment XXI ¶ 3.e.i.]

4. Cultural Competence; Prohibition on Discrimination. In addition to complying with other applicable standards:

a. Provider/Subcontractor shall cooperate in the implementation of, and comply with all requirements set forth in, Company's Cultural Competence Plan, which shall include implementation of the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). Provider/Subcontractor acknowledges and agrees that all Covered Services shall be provided in a culturally competent manner by ensuring the cultural competence of all Provider/Subcontractor staff, from clerical to executive management. Furthermore, Subcontractors shall complete Company's initial and annual cultural-competence training. [ICP Contract §§ 2.7, 2.7.3, 2.7.4; FHP-ACA Contract §§ 2.7, 2.7.3, 2.7.4; MLTSS Contract §§ 2.7, 2.7.3, 2.7.4]

b. Provider/Subcontractor shall abide by all federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Illinois Human Rights Act, and Executive Orders 11246 and 11375. Provider/Subcontractor furthermore agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Agreement. Provider/Subcontractor will furthermore not discriminate against Enrollees or prospective or potential Enrollees on the basis of health status, need for health services, or payment source. All Provider/Subcontractor locations where Enrollees receive Covered Services shall comply with the Americans with Disabilities Act of 1990. [77 Ill. Admin. Code § 240.50(d)(4); ICP Contract §§ 2.8, 5.6.2, 9.1.22; FHP-ACA Contract §§ 2.8, 5.7.2, 9.1.22; MLTSS Contract §§ 2.8, 5.6.2, 9.1.22]

5. Anti-Gag Clause; Prohibition on Retaliation. Provider/Subcontractor shall not be prohibited or otherwise restricted or discouraged from, and shall not prohibit or otherwise restrict or discourage its downstream providers or subcontractors from, taking any of the following actions so long as those actions are within the lawful scope of the acting party's practice: (a) advocating for medically appropriate health care services for Enrollees, which may include without limitation appealing denials and protesting decisions, policies, and practices; (b) advising an Enrollee about the health status of that Enrollee or medical care or treatment for that Enrollee's condition or disease regardless of whether benefits for such care or treatment are provided under the Agreement and/or the State Contracts; and/or (c) discussing with Enrollees, prospective Enrollees, or the public any health care services, health care providers, utilization review policies, quality assurance policies, or terms and conditions of plans and plan policy. Furthermore, Company shall not retaliate against Provider/Subcontractor, and Provider/Subcontractor shall not retaliate against its downstream providers or subcontractors, for any of the foregoing actions. Notwithstanding the foregoing, nothing in this provision shall be construed to prohibit: (a) Company or Provider/Subcontractor from making a determination not to pay for a particular health care service, from enforcing reasonable peer review or utilization review protocols, or from determining whether a physician or other health care provider has complied with those protocols; and/or (b) a Provider that is a hospital from taking disciplinary actions against a physician as authorized by law. [215 ILCS 134/30(a); 215 ILCS 134/35(a)–(d); ICP Contract § 5.32; FHP-ACA Contract § 5.32; MLTSS Contract § 5.31]

6. Grievances and Appeals. Provider/Subcontractor shall comply with Company's grievance and appeal processes referenced in the Agreement, and Company shall notify Provider/Subcontractor within fifteen (15) days following any substantive change to such procedures. [ICP Contract § 5.28.6; FHP-ACA Contract § 5.28.6; MLTSS Contract § 5.27.6]

7. Data and Reporting.

a. Provider/Subcontractor shall submit all data, reports, and clinical information required by Company under the State Contracts in such manner and format, and pursuant to such timeframes, as requested by Company and/or HFS. Provider/Subcontractor shall ensure that all data and reports that it submits to Company are accurate and complete, and Provider/Subcontractor furthermore acknowledges and agrees that all such data and reports shall be available to HFS and, upon request, to federal CMS. [ICP Contract § 5.24; FHP-ACA Contract § 5.24; MLTSS Contract § 5.23]

b. If Provider/Subcontractor provides Covered Services to Enrollees under a Illinois Department of Human Services ("DHS") Home and Community-Based Services ("HCBS") Waiver, under the Medicaid Clinic Option, or under the Medicaid Rehabilitation Option, or provides subacute alcoholism and substance-abuse treatment services pursuant to 89 Ill. Admin. Code §§ 148.340–148.390 and 77 Ill. Admin. Code Part 2090, such Provider/Subcontractor shall enter any data regarding Enrollees that is required under State rules, or under a contract between the Provider/Subcontractor and DHS, into any subsystem maintained by DHS, including, but not limited to, DHS's Automated Reporting and Tracking System (DARTS). [FHP-ACA Contract § 5.28.1.3; MLTSS Contract § 5.27.1.3]

8. Delegation. If Company delegates to Provider/Subcontractor any activities or obligations under the State Contracts:

a. Company shall remain ultimately responsible for the performance of those responsibilities and nothing in the Agreement shall be construed to terminate Company's legal responsibility to DHS to assure that all activities under the State Contracts are carried out. [ICP Contract §§ 5.28.2, 5.28.3; FHP-ACA Contract §§ 5.28.2, 5.28.3; MLTSS Contract §§ 5.27.2, 5.27.3]

b. Provider/Subcontractor acknowledges and agrees that Company's delegated oversight committee will oversee Provider/Subcontractor's activities and performance under the Agreement to ensure compliance with all applicable contractual and statutory requirements, including without limitation the Illinois Human Rights Act, the U.S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act. Company's oversight of Provider/Subcontractor will include, without limitation: pre-delegation audits; quarterly delegation oversight reviews of delegate performance; monthly joint-operation meetings; annual audits of Provider/Subcontractor; regular monitoring of Enrollee complaints with respect to Provider/Subcontractor; and documentation of issues and development of a corrective action plan, as warranted, to improve performance. [ICP Contract § 2.7.4; FHP-ACA Contract § 2.7.4; MLTSS Contract § 2.7.4]

c. To the extent that such delegated activities are credentialing or recredentialing activities or obligations under the State Contracts, Provider/Subcontractor shall maintain a formal credentialing program and shall conduct all such activities or obligations in compliance with Company, National Committee for Quality Assurance (NCQA), and State standards. Company shall monitor such credentialing/recredentialing delegated activities and shall review Provider/Subcontractor's credentialing files no less than annually as part of the annual audit. [ICP Contract § 5.7.4, Attachment XI ¶ 7.e.; FHP-ACA Contract § 5.8.4, Attachment XI ¶ 7.e.; MLTSS Contract § 5.7.4, Attachment XI ¶ 7.e.]

9. Offshore Services. Provider/Subcontractor is prohibited from using any individual or entity (an "Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative, or other individual or entity) to perform any services for Company 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/Subcontractor further agrees that Company has the right to audit any Offshore Entity prior to the provision of Offshore Services for Company. Provider/Subcontractor further represents and warrants that it does not and will not permit any Enrollee's protected health information (PHI) or other personal information to be accessible by any Offshore Entity, without prior written notice to Company and Company's prior written approval of such Offshore Entity. In the event that Company agrees in advance and in writing to permit Provider/Subcontractor to use an Offshore Entity to perform any services for Company and Company agrees that such Offshore Entity will receive, process, transfer, handle, store, or access Enrollee PHI as defined at 45 C.F.R. § 160.103, Provider/Subcontractor agrees that Offshore Services that involve Enrollee Member PHI may be subject to mandatory reporting to CMS and/or other applicable government regulators. [MLTSS Contract § 5.27.14]

10. Quality Assurance. With respect to Company's quality-assurance obligations under the State Contracts:

a. Provider/Subcontractor shall participate in and cooperate with Company's quality-assurance program (QAP), shall cooperate with Company with respect to Company's QAP obligations under the State Contracts, and shall cooperate with Company's quality improvement committee. Provider/Subcontractor shall furthermore allow Company to access Provider/Subcontractor's Enrollee

medical records to permit effective quality review and monitoring of Provider/Subcontractor's compliance with policies and procedures, specifications, and appropriateness of care, and such access shall include the right of Company to make and/or obtain a copy (in either electronic or hardcopy form) of such records. [ICP Contract, Attachment XI ¶ 6.b.; FHP-ACA Contract, Attachment XI ¶ 6.b.; MLTSS Contract, Attachment XI ¶¶ 2.b.ii., 6.b.]

b. Provider/Subcontractor shall provide, arrange for, or participate in the quality-assurance programs mandated by the Illinois Health Maintenance Organization Act, unless the Illinois Department of Public Health has certified that such programs will be fully implemented without any participation or action from Provider/Subcontractor. [215 ILCS 125/2-8(a); 50 Ill. Admin. Code § 5241.50(a)(4)]

c. Provider/Subcontractor acknowledges and agrees that Company shall perform quality-assurance evaluations of Provider/Subcontractor's practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. [ICP Contract § 2.7.5; FHP-ACA Contract § 2.7.5; MLTSS Contract § 2.7.5]

d. Provider/Subcontractor shall cooperate and comply with all remedial or corrective actions that Company implements with respect to Provider/Subcontractor and/or its services under the Agreement, upon Company's determination that Provider/Subcontractor has furnished inappropriate or substandard services or has failed to furnish services that should have been furnished. [ICP Contract, Attachment XI ¶ 3.e.; FHP-ACA Contract, Attachment XI ¶ 3.e.; MLTSS Contract, Attachment XI ¶ 3.e.]

e. If Company delegates to Provider/Subcontractor any quality-assurance activities or obligations that Company has under the State Contracts:

1. Company and Provider/Subcontractor shall agree in writing upon the delegated activities, the accountability of Provider/Subcontractor for those activities, and the frequency of Provider/Subcontractor's reporting to Company related to those activities. [ICP Contract, Attachment XI ¶ 7.a.; FHP-ACA Contract, Attachment XI ¶ 7.a.; MLTSS Contract, Attachment XI ¶ 7.a.]

2. Company and Provider/Subcontractor shall agree in writing upon the standards and procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided. [ICP Contract, Attachment XI ¶ 7.b.; FHP-ACA Contract, Attachment XI ¶ 7.b.; MLTSS Contract, Attachment XI ¶ 7.b.]

3. All such delegated activities shall conform to the requirements set forth in the State Contracts. [ICP Contract, Attachment XI ¶ 7.c.; FHP-ACA Contract, Attachment XI ¶ 7.c.; MLTSS Contract, Attachment XI ¶ 7.c.]

4. Provider/Subcontractor acknowledges and agrees that Company shall engage in continuous and ongoing evaluation and oversight of such delegated activities, including approval of quality-improvement plans and regular specified reports, as well as a formal review of such activities. Company's oversight of Provider/Subcontractor's performance of these delegated activities must include no less than an annual audit, analyses of required reports and encounter data, a review of Enrollee complaints, grievances, Provider complaints, and quality of care concerns raised through encounter data, monitoring activities, or other venues. Outcomes of Company's annual audit shall be submitted to HFS as part of Company's QA/UR/PR Annual Report. [ICP Contract, Attachment XI ¶ 7.d.; FHP-ACA Contract, Attachment XI ¶ 7.d.; MLTSS Contract, Attachment XI ¶ 7.d.]

5. If Company or Provider/Subcontractor identifies areas requiring improvement, Company or Provider/Subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, Provider/Subcontractor must develop and implement a corrective action plan, with protections put in place by Company to prevent such deficiencies from recurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to HFS through quarterly or annual reporting. [ICP Contract, Attachment XI ¶ 7 f.; FHP-ACA Contract, Attachment XI ¶ 7 f.; MLTSS Contract, Attachment XI ¶ 7.f.]

11. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy-related Covered Services under the ICP Contract and FHP-ACA Contract:

a. Provider/Subcontractor shall administer all pharmacy benefits in accordance with the provisions and requirements of the State Contracts and all applicable State and federal laws and regulations. [ICP Contract §§ 5.1.7, 5.16.6; FHP-ACA Contract §§ 5.2.5, 5.16.6]

b. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contracts to submit required pharmacy-related reports and data to applicable federal and State authorities. [ICP Contract, Attachment XIII; FHP-ACA Contract, Attachment XIII]

c. If Company delegates to Provider/Subcontractor any pharmacy-related activities or obligations that Company has under the State Contracts, Provider/Subcontractor shall comply with all pharmacy-related provisions and requirements set forth in the State Contracts, including without limitation the following, as applicable:

(i) Company and Provider/Subcontractor shall submit a pharmacy formulary for prior approval by the State initially and annually thereafter. [ICP Contract § 5.1.7; FHP-ACA Contract § 5.2.5]

(ii) Company and Provider/Subcontractor shall provide coverage of drugs in all classes of drugs for which HFS's fee-for-service program provides coverage. [ICP Contract § 5.1.7.1; FHP-ACA Contract § 5.2.5.1]

(iii) Company and Provider/Subcontractor shall cover only drugs made by manufacturers that participate in the federal Medicaid drug rebate program, which applies to both prescription and over-the-counter drugs, but does not apply to non-drug items such as blood sugar test strips. HFS will provide a listing of manufacturers that participate in the federal Medicaid drug rebate program. [ICP Contract § 5.1.7.2; FHP-ACA Contract § 5.2.5.2]

(iv) Company and Provider/Subcontractor may determine their own utilization controls, including without limitation step therapy and prior approval, unless otherwise prohibited under the State Contracts, to ensure appropriate utilization. Company and Provider/Subcontractor shall utilize HFS's step-therapy and prior-authorization requirements for family-planning drugs and devices as set forth in the State Contracts. [ICP Contract § 5.1.7.3; FHP-ACA Contract § 5.2.5.3]

(v) Company and Provider/Subcontractor shall ensure that they require pharmacy, medical, and hospital providers to identify 340B-purchased drugs on pharmacy, medical, and hospital claims following HFS billing guidelines applied in HFS's fee-for-service program, and Company and Provider/Subcontractor shall furthermore ensure that its encounter claims to HFS identify these drugs. [ICP Contract § 5.1.7.4; FHP-ACA Contract § 5.2.5.4] For any outpatient drugs *not* identified in accordance with the previous sentence: (i) Company and Provider/Subcontractor shall collect information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees, and (ii) Company and Provider/Subcontractor shall report to HFS quarterly, in a format and in the detail specified by HFS, information on the total number of units of each dosage form and strength and package size by National Drug Code of each such covered outpatient drug dispensed to Enrollees. [FHP-ACA Contract §§ 5.2.5.4.1, 5.2.5.4.2]

(vi) Company and Provider/Subcontractor shall establish and maintain a generic drug Maximum Allowable Cost (MAC) dispute-resolution process, subject to approval by HFS. The MAC dispute-resolution process shall enable pharmacies to report pricing disputes to the Company and/or Provider/Subcontractor up to sixty (60) days from the claim date and Company and/or Provider/Subcontractor is required to resolve the pricing dispute within twenty-one (21) days by adjusting the reimbursement rate to represent the average acquisition cost of the drug, or by informing the pharmacy of alternative generic equivalent products that can be purchased at or

below the Company's existing MAC price. [ICP Contract § 5.1.7.5; FHP-ACA Contract § 5.2.5.5]

(vii) Company and Provider/Subcontractor shall develop and implement a system, including policies and procedures, coverage criteria, and processes for their Drug Utilization Review (DUR) program. The DUR program shall include a prospective review process for all drugs prior to dispensing and all non-formulary drug requests, and a retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. Company and Provider/Subcontractor are required to report prospective and retrospective DUR activities to HFS quarterly, and to assist in data collection and reporting to HFS of data necessary to complete the federal CMS DUR annual report. [ICP Contract § 5.1.7.6; FHP-ACA Contract § 5.2.5.6]

(viii) Company and Provider/Subcontractor shall comply with the pharmacy prior-authorization provisions and requirements set forth in Section 5.16.6 of each of the State Contracts, which requires that Company and/or Provider/Subcontractor must authorize or deny a prior-authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization. [ICP Contract § 5.16.6; FHP-ACA Contract § 5.16.6]

(ix) Company and Provider/Subcontractor shall not permit or allow, whether by contract, written policy, or procedure, any individual or entity to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act (codified at 410 ILCS 620/3.14). [215 ILCS 134/30(b)]

12. Children's Mental Health Service Requirements. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to any behavioral-health Covered Services that Provider/Subcontractor provides to Enrollees under the age of twenty one (21):

a. Provider/Subcontractor shall administer all such behavioral-health benefits in accordance with the provisions and requirements of Attachment XXII of the FHP-ACA Contract and in accordance with all applicable State and federal laws and regulations. [FHP-ACA Contract, Attachment XXII]

b. If Provider is an inpatient psychiatric Provider, it shall administer a physical examination to the Enrollee within twenty-four (24) hours after admission when that Enrollee requires admission to an appropriate inpatient institutional treatment setting. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.iv.]

c. Provider shall comply with Company's procedures with respect to discharge and transitional planning related to an appropriate inpatient institutional treatment setting, and shall cooperate with Company in the education and training of the Enrollee's family on how to use the "crisis safety plans" while the Enrollee is receiving inpatient institutional treatment. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.v.5.]

d. If Provider/Subcontractor provides Mobile Crisis Response Services in connection with the State Contracts:

(i) Provider/Subcontractor shall ensure that the staff providing those services hold the following credentials: (a) Mental Health Professional (MHP) with direct access to a Qualified Mental Health professional; (b) Qualified Mental Health Professional; or (c) Licensed Practitioner of the Healing Arts. [FHP-ACA Contract, Attachment XXII, ¶ 3 f.]

(ii) Provider/Subcontractor shall provide immediate crisis and stabilization services when an Enrollee in crisis can be stabilized in the community. [FHP-ACA Contract, Attachment XXII, ¶ 4.a.i.]

(iii) Provider/Subcontractor shall establish a "crisis safety plan" for all Enrollees presenting in behavioral-health crisis that is unique to the Enrollee and the circumstances leading to the crisis situation. [FHP-ACA Contract, Attachment XXII, ¶¶ 4.a.ii., 4.b.i.]

(iv) Provider/Subcontractor shall provide the Enrollee's family with contact information that may be used at any time, 24 hours a day, to contact Company in moments of crisis. [FHP-ACA Contract, Attachment XXII, ¶ 4.a.iv.]

(v) Provider/Subcontractor shall provide families of Enrollees with physical copies of the "crisis safety plan" (a) prior to the completion of the crisis screening event for any Enrollee stabilized in the community, and (b) prior to discharge of the Enrollee from an inpatient psychiatric hospital for any Enrollee that is admitted to such a facility. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.ii.]

(vi) Provider/Subcontractor shall educate and orient the Enrollee's family to the components of the "crisis safety plan" to ensure that the plan is reviewed with the family regularly, and to detail how the plan is updated as necessary. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.iii.]

(vii) Provider/Subcontractor shall share the "crisis safety plan" with all necessary medical professionals, including care coordinators, consistent with the authorizations established by consent or release. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.iv.]

(viii) Provider/Subcontractor shall facilitate the Enrollee's admission to an appropriate inpatient institutional treatment setting when the Enrollee in crisis cannot be stabilized in the community. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.i.]

(ix) Provider/Subcontractor shall inform the Enrollee's parents, guardian, caregivers, or residential staff about all of the available service providers and pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.ii.]

13. Third-Party Payment Sources; Coordination of Benefits. Provider/Subcontractor acknowledges and agrees that Medicaid payment, under the State Contracts or otherwise, is secondary to other sources of payment (including Medicare) for Covered Services provided to Enrollees, and that Medicaid (and consequently Company, as a Medicaid MCO of the State) is the payer of last resort. Provider/Subcontractor furthermore acknowledges and agrees that to the extent Medicare has primary responsibility for a Covered Service, Company's obligation to pay for that Covered Service is only triggered if the State would have had a payment obligation as secondary payor on that Covered Service. [MLTSS Contract § 5.1] Provider/Subcontractor also acknowledges and agrees that when Company is aware of third-party sources of payment for Covered Services, Company is required to "cost avoid" (*i.e.*, deny) the associated claim and to redirect Provider/Subcontractor to bill that third-party source of payment as the primary payor.

14. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to submit financial and expense-related reports/data to the State relating to the risk adjustment and Medical Loss Ratio (MLR) adjustment set forth in the State Contracts. [ICP Contract §§ 7.4, 7.11; FHP-ACA Contract §§ 7.4, 7.11; MLTSS Contract §§ 7.4, 7.11]

b. Company's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [ICP Contract §§ 9.1.37, 9.1.38; FHP-ACA Contract §§ 9.1.36, 9.1.37; MLTSS Contract §§ 9.1.36, 9.1.37]

c. Company's obligation to provide a "medical home," as that term is used in the State Contracts, for its Enrollees. [ICP Contract §§ 5.5.7, 5.9.2; FHP-ACA Contract §§ 5.6.7, 5.9.2; MLTSS Contract §§ 5.5.7, 5.8.2]

d. Company's obligation to develop the Enrollee's care plan and to encourage Provider/Subcontractor to support Enrollees in directing their own care and in development of the Enrollee's care plan. [ICP Contract § 5.12.6; FHP-ACA Contract §§ 5.14.5, 5.14.8.1.3; MLTSS Contract §§ 5.13.5, 5.13.9.1, 5.13.9.2.3]

e. Company's obligation to avoid unnecessary utilization of emergency services by Enrollees and to promote care management through the Enrollees' primary care providers (PCPs) or "medical home." [ICP Contract § 5.17.1.5; FHP-ACA Contract § 5.17.1.5]

f. Company's obligation to establish and maintain an HFS-approved peer-review program to review the quality of care that Provider/Subcontractor provides to Enrollees. [ICP Contract § 5.19.5; FHP-ACA Contract § 5.19.5; MLTSS Contract § 5.18.5]

g. Company's obligation to provide orientation, education, and training for Provider/Subcontractor as set forth in the State Contracts, including without limitation (i) training on how to identify, recognize potential concerns related to, and report on suspected or alleged abuse, neglect, and exploitation being suffered by Enrollees, and (ii) education on the application of required clinical guidelines. [ICP Contract §§ 5.9, 5.20.1, 5.20.2, Attachment XI ¶ 9, Attachment XXI ¶ 3; FHP-ACA Contract §§ 5.9, 5.20.4, 5.20.5, Attachment XI ¶ 9, Attachment XXI ¶ 3; MLTSS Contract §§ 5.8, 5.19.4, 5.19.5, Attachment XI ¶ 9, Attachment XXI ¶ 3]

h. Company's obligation to participate in any State-required performance-improvement projects. [ICP Contract § 7.16.5; FHP-ACA Contract § 7.16.5; MLTSS Contract § 7.16.5]

i. Company's obligation to remit to Provider/Subcontractor, if applicable, any "hospital access payments" authorized under 305 ILCS 5/5A-12.2(s)–(t) and 305 ILCS 5/5A-12.5 (Public Act 98-651, enacted June 14, 2014). [ICP Contract § 7.1.5; FHP-ACA Contract § 7.1.2]

j. Company's obligation to respond to any letter of concern, written deficiency notice, or request for a corrective action plan that Company receives from the State relating to Provider/Subcontractor or the services that are within the scope of the Agreement. [ICP Contract § 7.16.6; FHP-ACA Contract § 7.16.6; MLTSS Contract § 7.16.6]

k. Company's obligations and responsibilities relating to the "HMO self-evaluation structure" and associated activities set forth in 77 Ill. Admin. Code § 240.60. [77 Ill. Admin. Code § 240.50(d)(1)(C)]

l. Company's obligations to coordinate Enrollees' care with any other entities involved in managing or coordinating that care, to collaborate and deliberate with those other entities as needed for care coordination and health-care decisions, to share with and receive information from those other entities as needed for care coordination, and to obtain any permissions (including without limitation any signed written permissions) necessary to facilitate such information-sharing, care coordination, and collaboration. [MLTSS Contract §§ 5.9.4, 5.10.1.6, 5.12.2.8, 5.13.9.1]

15. Notice of Legal Action. If Provider/Subcontractor, its parent, or one of its affiliates becomes a party to any litigation, investigation, or transaction that may reasonably be considered to have a material impact on Provider/Subcontractor's ability to perform under the Agreement, Provider/Subcontractor shall immediately notify Company in writing. [ICP Contract § 9.1.24; FHP-ACA Contract § 9.1.24; MLTSS Contract § 9.1.24]

16. State Review of Agreement. Provider/Subcontractor acknowledges and agrees that Company may be required to submit a copy of the Agreement to HFS for review, and that HFS reserves the right to require Company to amend the Agreement as reasonably necessary to conform to Company's duties and obligations under the State Contracts. [ICP Contract § 5.28.10; FHP-ACA Contract § 5.28.10; MLTSS Contract § 5.27.10]

17. Termination of Agreement and Effect Thereof.

a. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the parties. Furthermore, in the event this Illinois Medicaid Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or Product Participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties.

b. Notwithstanding anything in the Agreement to the contrary, if either Company or Provider/Subcontractor seeks (i) to terminate the Agreement "with cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least sixty (60) days' written notice to the other party; or (ii) to terminate the Agreement "without cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least ninety (90) days' written notice to the other party. Furthermore, Provider/Subcontractor shall cooperate with Company with respect to Company's obligation to provide timely notice to Enrollees of any termination that would curtail or eliminate services to such Enrollees, with such notice to be sent (i) at least sixty (60) days prior to that termination, or (ii) immediately, if Company receives less than sixty (60) days' notice of that termination from Provider/Subcontractor. The notice to be sent to Enrollees shall include instructions regarding referrals that have previously been issued and appointments that may be pending. [50 Ill. Admin. Code § 5241.50(a)(5)–(6); 305 ILCS 5/5F-40(a)]

c. Notwithstanding anything in the Agreement to the contrary, Company shall retain the right to terminate the Agreement, or impose other sanctions, if the performance of Provider/Subcontractor is inadequate. Company shall monitor the performance of Provider/Subcontractor on an ongoing basis, shall subject Provider/Subcontractor to formal review on no less than a triennial basis, and to the extent deficiencies or areas for improvement are identified during an informal or formal review, shall require Provider/Subcontractor to take appropriate corrective action. Furthermore, Company shall promptly terminate the Agreement if Provider/Subcontractor is or becomes terminated, barred, or suspended, or has voluntarily withdrawn as a result of a settlement agreement, under either Section 1128 or Section 1128A of the Social Security Act, from participating in any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act or are otherwise excluded from participation in the HFS Medical Program. [ICP Contract §§ 5.28.7, 5.28.9; FHP-ACA Contract §§ 5.28.7, 5.28.9; MLTSS Contract §§ 5.27.7, 5.27.9]

18. Maintenance, Access to, and Confidentiality of Records.

a. Provider/Subcontractor shall maintain books and records relating to the performance of the State Contracts and the Agreement and necessary to support amounts charged under the State Contracts and the Agreement. Books and records, including information stored in databases or other computer systems, shall be maintained by Provider/Subcontractor for a period of three (3) years from the later of the date of final payment under the Agreement or completion of the Agreement, or such longer time as may be required by federal law or regulation. Books and records required to be maintained under this provision shall be accessible for review or audit by representatives of Company or any Authorized Persons (along with the Executive Inspector General and the Chief Procurement Officer) upon reasonable notice and during normal business hours. Such access shall include the right to make and/or obtain a copy (in either electronic or hardcopy form) of such books and records. Provider/Subcontractor shall cooperate fully with any such audit and with any investigation conducted by any of these entities. Failure to maintain the books and records required by this provision shall establish a presumption in favor of the State for the recovery of any funds paid by the State under the State Contracts for which adequate books and records are not available to support the purported disbursement. Provider/Subcontractor shall not impose a charge for audit or examination of Provider/Subcontractor's books and records. [ICP Contract § 9.1.2; FHP-ACA Contract § 9.1.2; MLTSS Contract § 9.1.2]

b. Provider/Subcontractor may have or gain access to confidential data or information owned or maintained by the State or Company in the course of carrying out Provider/Subcontractor's responsibilities under the Agreement and/or the State Contracts. Provider/Subcontractor shall presume all information received from the State or Company, or to which it gains access pursuant to the Agreement and/or the State Contracts, is confidential. No confidential data collected, maintained, or used in the course of performance of the Agreement and/or the State Contracts shall be disseminated except as authorized by law and with the written consent of the State and/or Company, as applicable, either during the term of the State Contracts or thereafter, unless otherwise expressly provided in the State Contracts. Provider/Subcontractor must return any and all data collected, maintained, created, or used in the course of the performance of the Agreement and/or the State Contracts, in whatever form it is maintained, promptly at the earlier of the termination of the Agreement or the termination of the State Contracts, or earlier at the request of the State, or notify the State and/or Company, as applicable, in writing of its destruction. The foregoing obligations shall not apply to confidential data or information that is: (i) lawfully in Provider/Subcontractor's possession prior to its acquisition from the State and/or Company; (ii) received in

good faith from a third-party not subject to any confidentiality obligation to the State and/or Company; (iii) now is or later becomes publicly known through no breach of confidentiality obligation by Provider/Subcontractor; or (iv) is independently developed by Provider/Subcontractor without the use or benefit of the confidential information of the State and/or Company. [ICP Contract § 9.1.6; FHP-ACA Contract § 9.1.6; MLTSS Contract § 9.1.6]

c. Provider/Subcontractor shall ensure that all information, records, data, and data elements pertaining to applicants for and recipients of public assistance, or to providers, facilities, and associations, shall be protected from unauthorized disclosure by Provider/Subcontractor and Provider/Subcontractor's employees, by Provider/Subcontractor's corporate affiliates and their employees, and by Provider/Subcontractor's subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 U.S.C. § 654(26); 42 C.F.R. Part 431, Subpart F; and 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subparts A and E. To the extent that Provider/Subcontractor, in the course of performing under the terms of the Agreement, serves as a business associate of Company and/or HFS, as "business associate" is defined in the HIPAA Privacy Rule (45 C.F.R. § 160.103), Provider/Subcontractor shall assist Company and/or HFS in responding to the client as provided in the HIPAA Privacy Rule, and shall maintain for a period of six (6) years any records relevant to an individual's eligibility for services under the HFS Medical Program. [ICP Contract § 9.1.21; FHP-ACA Contract § 9.1.21; MLTSS Contract § 9.1.21]

d. Provider/Subcontractor, to which Company provides Enrollee PHI that Company has received from HFS or created or received by Company on behalf of HFS, agrees to the same restrictions, conditions, and requirements that apply under the terms of the State Contracts to Company with respect to such information. [ICP Contract, Attachment VI § C.5; FHP-ACA Contract, Attachment VI § C.5; MLTSS Contract, Attachment VI §§ B.4, B.5]

19. Medical Records. With respect to Enrollee medical records:

a. In addition to the requirements set forth in the Agreement, Provider/Subcontractor shall maintain Enrollee medical records in a timely, legible, accurate, current, complete, and organized manner, with appropriate dates and identification and initialing/signature of the Provider/Subcontractor, to facilitate retrieval and compilation of records, to ensure Enrollee continuity of care, and to permit effective and confidential patient care and quality review. For each encounter or episode of care that Provider/Subcontractor has with an Enrollee, Provider/Subcontractor shall place the following information into the Enrollee's medical records: (1) the reason for the encounter; (2) evidence of the Provider/Subcontractor's assessment of the Enrollee's health problems; (3) current diagnosis of the Enrollee, including the results of any diagnostic tests; (4) the plan of treatment, including any therapies and health education; (5) any medical history relevant to the current episode of care; and (6) confirmation that all outcomes of ancillary reports, such as laboratory tests and x-rays, have been reviewed by the individual or entity who ordered the reports and that follow-up actions have been taken regarding report results that are deemed significant by the individual or entity who ordered those reports. [77 Ill. Admin. Code §§ 240.50(c)(1), 240.90(a)–(b); ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3; MLTSS Contract § 5.22.3]

b. Provider/Subcontractor shall ensure that Enrollee medical records contain documented efforts to obtain Enrollee consent when required by law. Provider/Subcontractor shall furthermore only release Enrollee medical records to Authorized Persons, or to any primary care provider (PCP), women's health care provider (WHCP), or other Provider of Enrollee (subject to Enrollee's consent when required by law), and shall only release original Enrollee medical records in accordance with federal or State law, court orders, subpoenas, or a valid records-release form executed by the Enrollee. Provider/Subcontractor shall protect the confidentiality and privacy of minors, and shall abide by all federal and State laws regarding the confidentiality and disclosure of medical records, mental health records, and any other information about Enrollees. Provider/Subcontractor shall produce Enrollee medical records to HFS upon request. [ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3; MLTSS Contract § 5.22.3]

c. If Provider/Subcontractor is an Enrollee's primary care provider (PCP), Provider/Subcontractor shall furthermore maintain a permanent medical record for that Enrollee to ensure continuity of care. The medical record for each Enrollee who has had a routine, scheduled appointment with his/her primary care provider (PCP) shall include the following information: (1) identification; (2) patient history; (3) known past surgical procedures; (4) known past and current diagnoses and problems;

and (5) known allergies and untoward reactions to drugs. [77 Ill. Admin. Code § 240.90(c); ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

d. If Enrollee changes PCPs or "medical homes," Provider/Subcontractor shall forward Enrollee's medical records or copies thereof to the new PCP or "medical home" promptly upon Enrollee's transfer. [ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

e. Provider/Subcontractor shall only record diagnosis codes in Enrollee's medical records at the time of creation of that medical record, and shall not retroactively adjust any such diagnosis codes except to correct errors. [ICP Contract § 7.4.1; FHP-ACA Contract § 7.4.1]

20. Use of Hospitalists. Neither Company nor Provider/Subcontractor shall require or otherwise mandate, whether by contract, written policy, or procedure, any Enrollee to substitute his or her participating primary care provider (PCP) during inpatient hospitalization, such as with a hospitalist physician, without the agreement of that Enrollee's participating primary care provider (PCP). Company and Provider/Subcontractor (if applicable) shall inform Enrollees of any policies, recommendations, or guidelines concerning the substitution of the Enrollee's primary care provider (PCP) when hospitalization is necessary in the manner set forth in 215 ILCS 5/15(d)–(e). [215 ILCS 134/30(c)]

21. Provider Enrollment, Credentialing, Licensure, and Privileges.

a. Provider/Subcontractor shall be enrolled as a provider in the HFS Medical Program (as defined below), if such enrollment is required by HFS's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. Provider/Subcontractor shall not, in turn, contract or subcontract with an individual or entity that has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement. For purposes of this provision, the term "HFS Medical Program" means the (i) Illinois Medical Assistance Program administered under Article V of the Illinois Public Aid Code (305 ILCS 5/5-1 *et seq.*) or its successor program, and Titles XIX (42 U.S.C. § 1396 *et seq.*) and XXI (42 U.S.C. § 1397aa *et seq.*) of the Social Security Act, and Section 12-4.35 of the Illinois Public Aid Code (305 ILCS 5/12-4.35); and (ii) the State Children's Health Insurance Program administered under 215 ILCS 106 and Title XXI of the Social Security Act (42 U.S.C. § 1397aa *et seq.*). [ICP Contract §§ 1.71, 5.28.4; FHP-ACA Contract §§ 1.75, 5.28.4; MLTSS Contract §§ 1.74, 5.27.4]

b. Provider shall comply with all credentialing and recredentialing policies and procedures that Company implements to verify Provider's credentials, including without limitation by completing a credentialing application in accordance with applicable policies and procedures. Furthermore, Provider shall comply with all applicable credentialing/recredentialing standards and requirements set forth in the State Contracts and in applicable federal and State laws, regulations, and written policies. [ICP Contract § 5.7.1, Attachment XI ¶ 8; FHP-ACA Contract § 5.8.1, Attachment XI ¶ 8; MLTSS Contract § 5.7.1, Attachment XI ¶ 8]

c. If Provider/Subcontractor operates a laboratory testing site that provides services to Enrollees, (i) that site shall possess a valid Clinical Laboratory Improvement Amendment (CLIA) certificate and comply with the CLIA regulations found at 42 C.F.R. Part 493, and (ii) Provider/Subcontractor shall report lab values to Company directly. [ICP Contract §§ 5.19.2, 5.28.9.4; FHP-ACA Contract §§ 5.19.2, 5.28.9.4]

d. If Provider is a physician, such physician Provider shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is also a participating Provider with Company; or, in lieu of these admitting and/or delivery privileges, such physician Provider shall have a written referral agreement with a separate physician who is a participating Provider with Company and who has such privileges at a hospital that is also a participating Provider with Company. Such physician Provider shall coordinate care with the referring physician and shall ensure that Enrollee medical records are appropriately transferred; the physicians' written referral agreement shall contain appropriate provisions that document and require such coordination of care and transfer of medical records. [ICP Contract § 5.28.1.2; FHP-ACA Contract § 5.28.1.2; MLTSS Contract § 5.27.1.2]

e. If Provider/Subcontractor provides long-term care and HCBS services under the Agreement, Provider/Subcontractor shall be approved and authorized by the State to provide such Covered

Services, and shall only provide to Enrollees those particular Covered Services for which they are approved and authorized. [FHP-ACA Contract § 5.8.5; MLTSS Contract § 5.7.5]

22. Disclosure of Ownership and Control; Prohibited Relationships; Background Checks.

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in federal health care programs, or is 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, Provider/Subcontractor shall disclose to Company: any required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest information; and information on any criminal convictions regarding Provider/Subcontractor and any owner(s) and managing employee(s) at the time the Agreement is executed and annually thereafter, and any time there are changes to such information. [ICP Contract § 9.2.34; FHP-ACA Contract § 9.2.34; MLTSS Contract § 9.2.34]

b. No Provider/Subcontractor, no individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider/Subcontractor, and no officer, director, agent, or managing employee (*i.e.*, general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over that Provider/Subcontractor or who directly or indirectly conducts the day-to-day operation of that Provider/Subcontractor) shall be an entity or individual: (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)–(3) of the Social Security Act (42 U.S.C. § 1320a-7(b)(1)–(3)); (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a State health care program. [ICP Contract § 9.2.34; FHP-ACA Contract § 9.2.34; MLTSS Contract § 9.2.34]

c. Provider/Subcontractor shall not be an Excluded Person (as that term is defined below), and shall not employ, subcontract with, or affiliate with an Excluded Person. The term "Excluded Person" means any individual or entity that (i) under Section 1128 of the Social Security Act, is or has been terminated, barred, suspended, or otherwise excluded from participation in, or as the result of a settlement agreement has voluntarily withdrawn from participation in, any program under federal law, including any program under Titles IV, XVIII, XIX, XX or XXI of the Social Security Act; (ii) has not been reinstated in the program after a period of exclusion, suspension, debarment, or ineligibility; or (iii) has been convicted of a criminal offense related to the provision of items or services to a federal, state, or local government entity within the last ten (10) years. Provider/Subcontractor acknowledges and agrees that under the State Contracts, Company must terminate its relationship with Provider/Subcontractor immediately upon learning that such Provider/Subcontractor meets the definition of an Excluded Person, and must notify the HFS OIG of the termination. [ICP Contract §§ 5.22, 9.1.32; FHP-ACA Contract §§ 5.22, 9.1.32; MLTSS Contract §§ 5.21, 9.1.32]

d. Provider/Subcontractor acknowledges and agrees that prior to entering into the Agreement, Company may be required to submit a disclosure statement to HFS identifying any agreements, Providers, and/or Subcontractors in which any of the following have a financial interest of five percent (5%) or more: (a) any individual or entity also having a financial interest of five percent (5%) or more in Company or Company's affiliates as defined by 42 C.F.R. § 455.101; (b) any director, officer, trustee, partner, or employee of Company or Company's Affiliates; and (c) any member of the immediate family of any individual or entity designated above. [ICP Contract § 5.28.12; FHP-ACA Contract § 5.28.12; MLTSS Contract § 5.27.12]

e. Provider/Subcontractor acknowledges and agrees that the State may conduct, at the State's expense and whenever the State deems it reasonably necessary for security reasons, criminal and driver history background checks of Provider/Subcontractor and its officers, employees, or agents, and furthermore acknowledges and agrees that Provider/Subcontractor shall immediately reassign any such

individual who, in the opinion of the State, does not pass the background checks. [ICP Contract § 9.1.13; FHP-ACA Contract § 9.1.13; MLTSS Contract § 9.1.13]

23. Fraud, Abuse and Misconduct. Provider/Subcontractor shall report immediately in writing to Company and to the HFS OIG any suspected fraud, abuse, or misconduct associated with any service or function provided for under the Agreement and/or the State Contracts by any parties directly or indirectly affiliated with the Agreement and/or the State Contracts, including without limitation Company and Company's staff, Provider/Subcontractor and its employees and subcontractors, and HFS employees or contractors. Provider/Subcontractor shall make this report to Company and to the HFS OIG within three (3) days after first suspecting fraud, abuse, or misconduct. Provider/Subcontractor shall not conduct any investigation of the suspected fraud, abuse, or misconduct without the express concurrence of the HFS OIG; the foregoing notwithstanding, Provider/Subcontractor may conduct and continue investigations necessary to determine whether reporting is required under this provision. Provider/Subcontractor must report the results of such an investigation to the HFS OIG as described above. Provider/Subcontractor shall cooperate with all investigations of suspected fraud, abuse, or misconduct reported pursuant to this provision. Nothing in this provision precludes Company or Provider/Subcontractor from establishing measures to maintain quality of services and control costs that are consistent with their usual business practices, from conducting themselves in accordance with their respective legal or contractual obligations, or from taking internal personnel-related actions. [ICP Contract §§ 5.31.1, 9.1.29; FHP-ACA Contract §§ 5.31.1, 9.1.29; MLTSS Contract §§ 5.30.1, 9.1.29]

24. Business Enterprise Program (BEP) Registration. In the event that Provider/Subcontractor is a minority-owned business, a female-owned business, or a business owned by persons with disabilities, then Provider/Subcontractor shall seek and obtain State certification as a Business Enterprise Program (BEP) vendor under the Business Enterprise Program Act for Minorities, Females and Persons with Disabilities. Provider/Subcontractor shall furthermore cooperate with Company with respect to Company's obligations under the State Contract related to the Business Enterprise Program (BEP) and shall, among other things, maintain a record of all relevant data with respect to the utilization of BEP-certified individuals and entities, including, but not limited to, payroll records, invoices, canceled checks, and books of account, for a period of at least five (5) years after the completion of the Agreement. [ICP Contract §§ 2.9.2, 7.16.2; FHP-ACA Contract §§ 2.9.2, 7.16.2; MLTSS Contract §§ 2.9.2, 7.16.2]

25. Marketing Activities. Provider/Subcontractor shall not engage in any inappropriate or unallowable marketing activities and practices as set forth in the State Contracts and 42 C.F.R. § 438.104, and shall submit to Company for its review any marketing or information materials of Provider/Subcontractor that relate to the State Contracts, prior to disseminating same. Provider/Subcontractor furthermore shall not induce any employees of the State to improperly reveal any confidential information regarding Enrollees or otherwise use such confidential information in a fraudulent manner. [ICP Contract § 4.16.3; FHP-ACA Contract § 4.16.3; MLTSS Contract § 4.16.3]

26. Compliance with Laws, the State Contracts, and Company Policies and Procedures.

a. Provider/Subcontractor shall perform all services and other duties under the Agreement in accordance and compliance with, and subject to, all applicable federal, State, and local laws, rules, ordinances, regulations, orders, federal circulars, and license and permit requirements in the performance of the Agreement, including without limitation, the Managed Care Reform and Patient Rights Act (215 ILCS 134/ 1 *et seq.*), the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by the Illinois Department of Financial and Professional Regulation, the Illinois Department of Public Health, and/or federal CMS. Company shall be in compliance with applicable tax requirements and shall be current in payment of such taxes. Company shall obtain at its own expense all licenses and permissions necessary for the performance of the Agreement. [ICP Contract §§ 2.2, 2.5, 9.1.12; FHP-ACA Contract §§ 2.2, 2.5, 9.1.12; MLTSS Contract §§ 2.2, 2.5, 9.1.12]

b. Provider/Subcontractor shall be bound by the terms and conditions of the State Contracts that are appropriate to the services provided by, or activities delegated to, Provider/Subcontractor in connection with the State Contracts. These terms and conditions include, without limitation, the record-keeping and audit provisions of the State Contracts, such that the Authorized Persons shall have the same rights to audit and inspect Provider/Subcontractor (and any downstream providers or subcontractors thereof) as they have to audit and inspect Company. [ICP Contract § 5.28.1.1; FHP-ACA Contract § 5.28.1.1; MLTSS Contract § 5.27.1.1]

c. Provider/Subcontractor shall comply with the prior-authorization requirements and processes set forth in Company's policies and procedures. [ICP Contract §§ 5.16.5, 5.16.6; FHP-ACA Contract § 5.16.5, 5.16.6; MLTSS Contract §§ 5.15.5, 5.15.6]

d. Provider/Subcontractor shall comply with all utilization-management and peer-review programs, processes, and timeframes established by Company. [ICP Contract, Attachment XII ¶ 4; FHP-ACA Contract, Attachment XII ¶ 4; MLTSS Contract, Attachment XII ¶ 4]

27. State Employee Handbook. If Provider/Subcontractor or any of its employees and subcontractors provide services under the Agreement at a location controlled by HFS or any other State agency, Provider/Subcontractor shall abide by all applicable provisions of the controlling State agency's Employee Handbook. [ICP Contract § 9.1.27; FHP-ACA Contract § 9.1.27; MLTSS Contract § 9.1.27]

28. Prohibition on Gifts. Provider/Subcontractor and its principals, employees, and subcontractors are prohibited from giving gifts to HFS employees, and from giving gifts to, or accepting gifts from, any individual or entity that has a contemporaneous contract with HFS involving duties or obligations related to the Agreement and/or the State Contracts. [ICP Contract § 9.1.30; FHP-ACA Contract § 9.1.30; MLTSS Contract § 9.1.30]

29. No Transfer of Liability to Providers. Neither Company nor Subcontractor shall transfer or attempt to transfer to any health care provider, by indemnification, hold harmless, or contribution requirements that are set forth in any contract, written policy, or procedure, any liability relating to activities, actions, or omissions of Company and/or Subcontractor or their respective officers, employees, or agents; provided, however that nothing in this provision shall relieve any health care provider from liability for his, her, or its own negligence in the performance of his, her, or its duties arising from treatment of an Enrollee. [215 ILCS 134/95]

30. Capitated Contracts. If Company compensates Provider/Subcontractor under the Agreement on a capitated basis for furnishing, arranging, or providing health care services:

a. Provider/Subcontractor agrees that in no event, including but not limited to nonpayment by Company of amounts due to Provider/Subcontractor under the Agreement, insolvency of Company, or any breach of the Agreement by Company, shall Provider/Subcontractor or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Enrollee or persons acting on the Enrollee's behalf (other than Company) for services provided pursuant to the Agreement, except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Enrollees and persons acting on the Enrollees' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider/Subcontractor and the Enrollee or persons acting on the Enrollee's behalf (other than Company). [50 Ill. Admin. Code § 5241.50(e)]

b. Provider/Subcontractor shall submit timely encounter data/records for all Covered Services that it has provided to Enrollees, in the format specified by the State, so that Company can meet the encounter-reporting specifications and requirements set forth in the State Contracts. Provider/Subcontractor shall be responsible for transmitting all data to Company as required by 42 C.F.R. § 438. [ICP Contract § 7.11.3; FHP-ACA Contract §§ 5.6.6, 7.11.3; MLTSS Contract §§ 5.5.6, 7.11.3]

c. If Provider/Subcontractor is a "Managed Care Organization" as that term is defined in 50 Ill. Admin. Code § 5241.20, Provider/Subcontractor shall submit to Company copies of Provider/Subcontractor's quarterly financial statements, which shall include Provider/Subcontractor's balance sheet and statements of income and cash flow within forty-five (45) days after the end of each fiscal period. In addition, Provider/Subcontractor shall submit, within ninety (90) days after the end of Provider/Subcontractor's fiscal year, copies of Provider/Subcontractor's audited annual financial statements prepared in accordance with generally accepted accounting principles, if available. Provider/Subcontractor acknowledges and agrees that HFS, at its discretion, may require Company to submit for HFS's inspection the financial statements that Company has received from Provider/Subcontractor (which such financial statements shall be deemed confidential by HFS). Provider/Subcontractor agrees to fully cooperate with, and disclose all relevant information requested by, Company's actuaries for the preparation of such actuaries' opinion in accordance with the Actuarial

Standards Board Actuarial Standards of Practice No. 16. Company acknowledges that in the event of Provider/Subcontractor's insolvency, Company is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Company's Enrollees. [50 Ill. Admin Code §5241.50(d)] For purposes of this provision, "Managed Care Organization" or "MCO" means a partnership, association, corporation, or other legal entity, including but not limited to individual practice associations (IPAs) and physician hospital organizations (PHOs), that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services. [50 Ill. Admin. Code § 5241.20]

31. Required Certifications of Provider/Subcontractor. Provider/Subcontractor acknowledges and agrees that its compliance with Section 9.2 of each of the State Contracts and each subsection of Section 9.2 (collectively, the "Standard Certifications") is a material requirement and condition of this Agreement during the entire term thereof, including during any renewal periods. By executing the Agreement, Provider/Subcontractor certifies compliance with the Standard Certifications in their entirety, and Provider/Subcontractor is under a continuing obligation to remain in compliance with, and to report any non-compliance with respect to, the Standard Certifications. Furthermore, Provider/Subcontractor shall include the Standard Certifications in any subcontracts or other contracts with its downstream entities or related entities that Provider/Subcontractor enters into in connection with the State Contracts. During the term of the State Contracts, Provider/Subcontractor shall confirm compliance with the Standard Certifications in the manner and format determined by the State by the date specified by the State, and in no event later than July 1 of each year that the State Contracts remains in effect. As part of each Standard Certification, Provider/Subcontractor acknowledges and agrees that if Provider/Subcontractor or its subcontractors, downstream entities, or related entities provide false information, or fail to be or remain in compliance with the Standard Certifications, one or more of the following sanctions will apply: (a) the Agreement may be void by operation of law; (b) the State may void the Agreement; and (c) Provider/Subcontractor and its subcontractors, downstream entities, or related entities may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty. [ICP Contract § 9.2.1; FHP-ACA Contract § 9.2.1; MLTSS Contract § 9.2.1]

The Standard Certifications are set forth below:

b. Provider/Subcontractor certifies it and its employees will comply with applicable provisions of the United States Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101, *et seq.*), and applicable rules in the performance of this Agreement. [ICP Contract § 9.2.2; FHP-ACA Contract § 9.2.2; MLTSS Contract § 9.2.2]

c. Provider/Subcontractor certifies, if applicable, that it is not in default on an educational loan (5 ILCS 385/3). This applies to individuals, sole proprietorships, partnerships, and individuals as members of LLCs. [ICP Contract § 9.2.3; FHP-ACA Contract § 9.2.3; MLTSS Contract § 9.2.3]

d. Provider/Subcontractor (if an individual, sole proprietor, partner, or an individual as member of an LLC) certifies, if applicable, that it has not received (i) an early retirement incentive prior to 1993 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133.3, or (ii) an early retirement incentive on or after 2002 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133 (30 ILCS 105/15a). [ICP Contract § 9.2.4; FHP-ACA Contract § 9.2.4; MLTSS Contract § 9.2.4]

e. Provider/Subcontractor certifies, if applicable, that it is a properly formed and existing legal entity (30 ILCS 500/1.15.80, 20-43), and as applicable has obtained an assumed name certificate from the appropriate authority, or has registered to conduct business in Illinois and is in good standing with the Illinois Secretary of State. [ICP Contract § 9.2.5; FHP-ACA Contract § 9.2.5; MLTSS Contract § 9.2.5]

f. Provider/Subcontractor certifies that it has neither been convicted of bribing or attempting to bribe an officer or employee of the State or any other state, nor made an admission of guilt of such conduct that is a matter of record (30 ILCS 500/50-5). [ICP Contract § 9.2.7; FHP-ACA Contract § 9.2.7; MLTSS Contract § 9.2.7]

g. If Provider/Subcontractor has been convicted of a felony, Provider/Subcontractor certifies at least five (5) years have passed after the date of completion of the sentence for such felony, unless no person held responsible by a prosecutor's office for the facts upon which the conviction was based

continues to have any involvement with the business (30 ILCS 500/50-10). [ICP Contract § 9.2.8; FHP-ACA Contract § 9.2.8; MLTSS Contract § 9.2.8]

h. If Provider/Subcontractor, or any officer, director, partner, or other managerial agent of Provider/Subcontractor, has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law of 1953, Provider/Subcontractor certifies that at least five (5) years have passed since the date of the conviction. Provider/Subcontractor further certifies that it is not barred from being awarded a contract and acknowledges that the State shall declare the Agreement void if this certification is false (30 ILCS 500/50-10.5). [ICP Contract § 9.2.9; FHP-ACA Contract § 9.2.9; MLTSS Contract § 9.2.9]

i. Provider/Subcontractor certifies that it is not barred from having a contract with the State based on violating the prohibition on providing assistance to the State in identifying a need for a contract (except as part of a public request for information process) or by reviewing, drafting, or preparing a solicitation or similar documents for the State (30 ILCS 500/50-10.5e). [ICP Contract § 9.2.10; FHP-ACA Contract § 9.2.10; MLTSS Contract § 9.2.10]

j. Provider/Subcontractor certifies that it and its affiliates are not delinquent in the payment of any debt to the State (or if delinquent has entered into a deferred payment plan to pay the debt), and Provider/Subcontractor and its affiliates acknowledge that the State may declare the Agreement void if this certification is false (30 ILCS 500/50-11) or if Provider/Subcontractor or an affiliate later becomes delinquent and has not entered into a deferred payment plan to pay off the debt (30 ILCS 500/50-60). [ICP Contract § 9.2.11; FHP-ACA Contract § 9.2.11; MLTSS Contract § 9.2.11]

k. Provider/Subcontractor certifies that it and its affiliates shall collect and remit Illinois Use Tax on all sales of tangible personal property into the State in accordance with provisions of the Illinois Use Tax Act (30 ILCS 500/50-12) and acknowledges that failure to comply can result in the Agreement being declared void. [ICP Contract § 9.2.12; FHP-ACA Contract § 9.2.12; MLTSS Contract § 9.2.12]

l. Provider/Subcontractor certifies that it has not been found by a court or the Pollution Control Board to have committed a willful or knowing violation of the Environmental Protection Act within the last five (5) years, and is therefore not barred from being awarded a contract (30 ILCS 500/50-14). [ICP Contract § 9.2.13; FHP-ACA Contract § 9.2.13; MLTSS Contract § 9.2.13]

m. Provider/Subcontractor certifies that it has not paid any money or valuable thing to induce any person to refrain from bidding on a State contract, nor has Provider/Subcontractor accepted any money or other valuable thing, or acted upon the promise of same, for not bidding on a State contract (30 ILCS 500/50-25). [ICP Contract § 9.2.14; FHP-ACA Contract § 9.2.14; MLTSS Contract § 9.2.14]

n. Provider/Subcontractor certifies that it is not in violation of the "Revolving Door" section of the Illinois Procurement Code (30 ILCS 500/50-30). [ICP Contract § 9.2.15; FHP-ACA Contract § 9.2.15; MLTSS Contract § 9.2.15]

o. Provider/Subcontractor certifies that it has not retained a person to attempt to influence the outcome of a procurement decision for compensation contingent in whole or in part upon the decision or procurement (30 ILCS 500/50-38). [ICP Contract § 9.2.16; FHP-ACA Contract § 9.2.16; MLTSS Contract § 9.2.16]

p. Provider/Subcontractor certifies that it will report to the Illinois Attorney General and the Chief Procurement Officer any suspected collusion or other anti-competitive practice among any bidders, offerors, contractors, proposers, or employees of the State (30 ILCS 500/50-40, 50-45, 50-50). [ICP Contract § 9.2.17; FHP-ACA Contract § 9.2.17; MLTSS Contract § 9.2.17]

q. In accordance with the Steel Products Procurement Act, Provider/Subcontractor certifies that steel products used or supplied in the performance of a contract for public works shall be manufactured or produced in the United States, unless the executive head of the procuring agency grants an exception (30 ILCS 565). [ICP Contract § 9.2.18; FHP-ACA Contract § 9.2.18; MLTSS Contract § 9.2.18]

r. If Provider/Subcontractor employs twenty-five (25) or more employees, Provider/Subcontractor certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580). [ICP Contract § 9.2.19; FHP-ACA Contract § 9.2.19; MLTSS Contract § 9.2.19]

s. Provider/Subcontractor certifies that neither Provider/Subcontractor nor any substantially owned affiliate of Provider/Subcontractor is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce (30 ILCS 582). [ICP Contract § 9.2.20; FHP-ACA Contract § 9.2.20; MLTSS Contract § 9.2.20]

t. Provider/Subcontractor certifies that it has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33E-3, E-4). [ICP Contract § 9.2.21; FHP-ACA Contract § 9.2.21; MLTSS Contract § 9.2.21]

u. Provider/Subcontractor certifies that it complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105). [ICP Contract § 9.2.22; FHP-ACA Contract § 9.2.22; MLTSS Contract § 9.2.22]

v. Provider/Subcontractor certifies that it does not pay dues to or reimburse or subsidize payments by its employees for any dues or fees to any "discriminatory club" (775 ILCS 25/2). [ICP Contract § 9.2.23; FHP-ACA Contract § 9.2.23; MLTSS Contract § 9.2.23]

w. Provider/Subcontractor certifies that it complies with the State Prohibition of Goods from Forced Labor Act, and certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Agreement have been or will be produced in whole or in part by forced labor, or indentured labor under penal sanction (30 ILCS 583). [ICP Contract § 9.2.24; FHP-ACA Contract § 9.2.24; MLTSS Contract § 9.2.24]

x. Provider/Subcontractor certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Agreement have been produced in whole or in part by the labor or any child under the age of twelve (30 ILCS 584). [ICP Contract § 9.2.25; FHP-ACA Contract § 9.2.25; MLTSS Contract § 9.2.25]

y. Provider/Subcontractor certifies that it is not in violation of Section 50-14.5 of the Illinois Procurement Code (30 ILCS 500/50-14.5), which states: "Owners of residential buildings who have committed a willful or knowing violation of the Lead Poisoning Prevention Act (410 ILCS 45) are prohibited from doing business with the State until the violation is mitigated." [ICP Contract § 9.2.26; FHP-ACA Contract § 9.2.26; MLTSS Contract § 9.2.26]

z. Provider/Subcontractor warrants and certifies that it and, to the best of its knowledge, its subcontractors, downstream entities, or related entities, have and will comply with Executive Order No. 1 (2007). That Order generally prohibits contractors and subcontractors from hiring the then-serving Illinois Governor's family members to lobby procurement activities of the State, or any other unit of government in the State including local governments if that procurement may result in a contract valued at over $25,000. This prohibition also applies to hiring for that same purpose any former State employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity. [ICP Contract § 9.2.27; FHP-ACA Contract § 9.2.27; MLTSS Contract § 9.2.27]

aa. Provider/Subcontractor certifies that information technology, including electronic information, software, systems, and equipment developed or provided under the Agreement will comply with the applicable requirements of the Illinois Information Technology Accessibility Act Standards as published at www.dhs.state.il.us/iitaa (30 ILCS 587). [ICP Contract § 9.2.28; FHP-ACA Contract § 9.2.28; MLTSS Contract § 9.2.28]

bb. Provider/Subcontractor certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal or State department or agency, and is not currently barred or suspended from contracting with the State

under Section 50-35(f), 50-35(g) or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 *et seq.* If at any time during the term of the Agreement, Provider/Subcontractor becomes barred, suspended, or excluded from participation in this transaction, Provider/Subcontractor shall, within thirty (30) days after becoming barred, suspended, or excluded, provide to HFS a written description of each offense causing the exclusion, the date(s) of the offense(s), the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence completed. [ICP Contract § 9.2.29; FHP-ACA Contract § 9.2.29; MLTSS Contract § 9.2.29]

cc. Provider/Subcontractor certifies that neither Provider/Subcontractor, nor any party directly or indirectly affiliated with Provider/Subcontractor, including but not limited to Provider/Subcontractor's officers, directors, employees, and subcontractors, and the officers, directors, and employees of Provider/Subcontractor's subcontractors, shall have or acquire any Conflict of Interest (as defined below) in performance of the Agreement. Provider/Subcontractor shall disclose in writing any Conflicts of Interest to HFS no later than seven (7) days after learning of the Conflict of Interest. HFS may initiate any inquiry as to the existence of a Conflict of Interest, and Provider/Subcontractor shall cooperate with all such inquiries. HFS shall determine, in its sole discretion, whether a Conflict of Interest exists or whether Provider/Subcontractor failed to make any required disclosure. If HFS concludes that a Conflict of Interest exists, or that Provider/Subcontractor failed to disclose any Conflict of Interest, HFS may impose one or more remedies in its sole discretion, including without limitation the elimination of the Conflict of Interest or the non-renewal or termination of the Agreement. [ICP Contract § 9.2.30; FHP-ACA Contract § 9.2.30; MLTSS Contract § 9.2.30]

i. For purposes of this provision, "Conflict of Interest" shall mean an interest of Provider/Subcontractor, or any entity described above, which may be direct or indirect, professional, personal, financial, or beneficial in nature that, in the sole discretion of HFS, compromises, appears to compromise, or gives the appearance of impropriety with regard to Provider/Subcontractor's duties and responsibilities under the Agreement. This term shall include potential Conflicts of Interest. A Conflict of Interest may exist even if no unethical or improper act results from it or may arise where Provider/Subcontractor becomes a party to any litigation, investigation, or transaction that materially impacts Provider/Subcontractor's ability to perform under the Agreement. Any situation where Provider/Subcontractor's role under the Agreement competes with Provider/Subcontractor's professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable individual, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur, or that gives the appearance of the existence of bias or improper conduct, is a Conflict of Interest. [ICP Contract § 9.2.30.1; FHP-ACA Contract § 9.2.30.1; MLTSS Contract § 9.2.30.1]

dd. Provider/Subcontractor certifies that it is in compliance with all applicable standards, orders, or regulations issued pursuant to the federal Clean Air Act (42 U.S.C. § 7401 *et seq.*) and the federal Water Pollution Control Act (33 U.S.C. § 1251 *et seq.*). Violations shall be reported to the United States Department of Health and Human Services and the appropriate Regional Office of the United States Environmental Protection Agency. [ICP Contract § 9.2.31; FHP-ACA Contract § 9.2.31; MLTSS Contract § 9.2.31]

ee. Provider/Subcontractor certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of Provider/Subcontractor, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, Provider/Subcontractor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such form is to be obtained at Provider/Subcontractor's request from the HFS Bureau of Fiscal Operations. Provider/Subcontractor shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall

certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when the Agreement was executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure. [ICP Contract § 9.2.32; FHP-ACA Contract § 9.2.32; MLTSS Contract § 9.2.32]

ff. Provider/Subcontractor certifies that it has read, understands, and is in compliance with the registration requirements of the Elections Code (10 ILCS 5/9-35) and the restrictions on making political contributions and related requirements of the Illinois Procurement Code (30 ILCS 500/20-160 and 50-37). Provider/Subcontractor will not make a political contribution that will violate these requirements, which are effective for the duration of the term of office of the incumbent State governor or for a period of two (2) years after the end of the Agreement's term, whichever is longer. Provider/Subcontractor will certify, as applicable, either that it is not required to register as a business entity with the State Board of Elections, or has registered with the State Board of Elections and will appropriately and timely update that registration. [ICP Contract § 9.2.33 & Attachment X; FHP-ACA Contract § 9.2.33 & Attachment X; MLTSS Contract § 9.2.33 & Attachment X]

Individual Sites Regulatory Addendum – Exhibit A

Florida Medicaid and Florida Healthy Kids Compliance Addendum - Subcontractor

Coventry Health Care of Florida, Inc., an Aetna Company (hereinafter "Company" or "Coventry") contracts with Florida Agency for Health Care Administration ("AHCA") and Florida Healthy Kids Corporation ("FHKC") (AHCA and FHKC are collectively referred to herein as "Agency") to provide Medicaid managed care and other public health services to beneficiaries (collectively referred to as the "State Contract").

This Florida Medicaid Compliance Addendum ("Addendum") is incorporated by reference into the Agreement. If there is any conflict between the terms of this Addendum and any 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 the terms of the Agreement, including this Addendum, and the State Contract, as amended, then the terms of the State Contract will govern and control.

For purposes of this Addendum, the term "Subcontractor" shall mean the individual or entity executing the Agreement, as identified on the first page of the Agreement, which may be a health care physician, provider, group, facility, hospital, an individual, entity or delegated entity.

This Addendum shall apply to services performed on behalf of Company's Florida Members. To the extent applicable to the services provided by Subcontractor pursuant to the Agreement, the following provisions apply:

I. Records. Subcontractor shall maintain books, records, and documents (including electronic storage media) pertinent to performance under the Agreement in accordance with generally accepted accounting procedures and practices, which sufficiently and properly reflect all revenues and expenditures of funds provided under the Agreement. Subcontractor shall make these records subject at all reasonable times to inspection, review, or audit by state personnel and other personnel duly authorized by the Agency, as well as by federal personnel.

Subcontractor shall maintain records relating to the Agreement for a period not less than ten (10) years from the close of the State Contract and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Company if the Agreement is continuous.

Subcontractor shall submit all reports and clinical information required by Company as applicable.

II. Compliance. Subcontractor shall comply with:

1. The privacy and security provisions of the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164.
2. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin.
3. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap.
4. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex.
5. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age.
6. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.
7. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.
8. All regulations, guidelines, and standards as are now or may be lawfully adopted under the above statutes.
9. Section 274A(e) of the Immigration and Nationality Act and shall not knowingly employ unauthorized aliens. Subcontractor shall utilize the E-Verify system to verify the employment eligibility of all new

employees hired by the subcontractor performing work or providing services pursuant to the Agreement. Violation of this section shall be cause for unilateral cancellation of this Agreement by Company.

10. The False Claims Act, 31 USC § 3729, and all relevant whistleblower protections.
11. All state and federal marketing requirements, including 42 CFR 438.104 and Florida Statutes §§ 409.912, 641.3901, 641.3903, 641.386, 626.112, 626.342, 626.451, 626.471, 626.511, 626.611, 626.9541, and 626.9521.
12. All state and federal law governing the monitoring, interception, recording, use or disclosure of wire, oral, or electronic communications, including but not limited to the Florida Security of Communications Act, §§ 934.01 et. seq., Florida Statutes, and the Electronic Communications Privacy Act, 18 USC § 2510 et seq. (collectively "Communication Privacy Laws"). Prior to intercepting, recording, or monitoring any communications which are subject to Communication Privacy Laws, Subcontractor shall submit a plan to Company, which shall submit it for approval by the Agency.
13. The applicable provisions of 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106 as relate to sub contractual relationships and delegation, and disclosure of information on ownership, control, business transactions, and criminal convictions.

III. Oversight.

Company shall provide a mechanism for requiring corrective action, revoking delegation, or imposing other sanctions if Subcontractor's performance is inadequate.

The Agency and the U.S. Department of Health and Human Services may evaluate, through inspection of records pertinent to the State Contract or other means, the quality, appropriateness, and timeliness of services performed.

Subcontractor shall provide full cooperation in any investigation by the Agency, Medicaid Provider Integrity, Medicaid Fraud Control Unit, Department of Elder Affairs, or other state or federal entity or any subsequent legal action that may result from such an investigation.

Subcontractor shall be subject to background checks at such level and scope determined by Company.

Upon request and as required by state and/or federal law, Subcontractor shall make available to all authorized federal and state oversight agencies and their agents, including but not limited to, the Agency, the Florida Attorney General, and Department of Financial Services any and all administrative, financial and medical/case records and data relating to the delivery of items or services for which Medicaid monies are expended.

Subcontractor shall allow access to all authorized federal and state oversight agencies and their agents, including but not limited to, the Agency, the Florida Attorney General, and Department of Financial Services to any place of business and all medical/case records and data, as required by state and/or federal law. Access shall be during normal business hours, except under special circumstances when the Agency, Florida Attorney General, and Department of Financial Services shall have after hours admission. The Agency and Florida Attorney General shall determine the need for special circumstances.

Subcontractor shall be eligible for participation in the Medicaid program; however, Subcontractor is not required to participate in the Medicaid program as a provider.

Subcontractor may not seek payment from a Medicaid pending enrollee on behalf of Company.

Subcontractor shall participate in applicable internal and external quality improvement, utilization review, peer review, and grievance procedures established by Company.

IV. Amendment. If the Agency determines, at any time, that the Agreement is not in compliance with the Contract, Company may unilaterally amend the Agreement to bring it into compliance.

V. Termination. In addition to any other right to terminate in the Agreement or the State Contract, Company may request immediate termination of the Agreement, to the extent applicable to services provided by Subcontractor to Company under the State Contract, if Subcontractor fails to abide by the terms and conditions of the Agreement and

fails to come into compliance, in Company's discretion, with the Agreement within fifteen (15) calendar days after receipt of notice from Company of Subcontractor's failure to abide by the terms of the Agreement.

VI. Miscellaneous. Subcontractor shall not provide or assist in the completion of enrollment or disenrollment requests or restrict the enrollee's right to disenroll voluntarily in any way.

If Subcontractor is conducting credentialing, Subcontractor shall conduct credentialing of providers in accordance with Company's and the Agency's credentialing requirements as found in the State Contract.

Subcontractor shall comply with Company's cultural competency plan.

The individual signing the Agreement has authority to do so. The Agreement includes all of the requirements of the State Contract.

Subcontractor agrees that patients, AHCA, and Company shall not be held liable for any of Subcontractor's debts. This provision shall survive termination of the Agreement, including breach due to insolvency.

Subcontractor shall indemnify, defend, and hold the Agency, its designees and Company's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause shall survive termination of the Agreement, including breach due to insolvency. The Agency may waive this requirement for itself, but not Company's enrollees, for damages in excess of the statutory cap on damages for public entities, if Subcontractor is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency.

Subcontractor shall secure and maintain, during the life of the Agreement, workers' compensation insurance for all of its employees connected with the work under this the Agreement unless such employees are covered by the protection afforded by Company. Such insurance shall comply with the Florida Workers' Compensation Law.

If Subcontractor delegates or subcontracts any functions of the Agreement, the subcontract or delegation shall include all of the requirements of the Agreement.

Provisions of this Agreement that are in conflict with the specifications of the State Contract are waived.

If Subcontractor will conduct utilization management activities, Company and Subcontractor shall ensure that the Agreement does not structure compensation so as to provide incentives for Subcontractor to deny, limit, or discontinue medically necessary services to any enrollee.

SKYGEN/Scion Dental Subcontractor Agreement

FIRST AMENDMENT TO THE
COVENTRY HEALTH CARE OF WEST VIRGINIA, INC.
LETTER OF AGREEMENT

THIS FIRST AMENDMENT is effective on or about June 1, 2018 ("Effective Date"), and is between Coventry Health Care of West Virginia, Inc. d/b/a Aetna Better Health of West Virginia, on behalf of itself and its Affiliates ("Company") and Scion Dental, LLC, as successor by conversion to Scion Dental, Inc. ("Provider") (the "First Amendment").

WHEREAS, Company and Provider entered into a Coventry Health Care Letter Of Agreement dated January 1, 2014 ("Agreement") for the provision of certain covered services contemplated in the Agreement; and

WHEREAS, Company and Provider desire to amend the Agreement as set forth in this First Amendment.

NOW, THEREFORE, in consideration of the mutual covenants and promises stated herein and in the Agreement, and other good and valuable consideration, Company and Provider agree as follows:

1. Article I Sections 1.1(a) and (b) of the Agreement are deleted in their entirety and replaced with the reports set forth on Exhibit A to this First Amendment.

2. Article I Sections 1.2(a)-(r) of the Agreement are deleted in their entirety and replaced with the delegated services set forth on Exhibit B to this First Amendment.

3. The following provision is added to the Agreement as Article II, Section 2.5:

   "Program Contract. Company shall provide to Provider the current Program Contract between the State of West Virginia Department of Health and Human Resources Bureau for Medical Services and Company. Company shall provide to Provider, with at least thirty (30) days prior written notice, any modification to such Program Contract that affects Provider's provision of Administrative Services under this Agreement."

4. Article III section 3.1 of the Agreement is hereby deleted in its entirety and replaced with the following: "As of the Effective Date, Company shall pay Provider in accordance with the terms and conditions of the Compensation Schedule attached as Exhibit C."

5. The following provision is added to the Agreement as Article III, Section 3.3:

   "Definition. For purposes of this Agreement, the terms set forth below shall have the following meanings:
   (a) Agency. "Agency" means a federal, state, or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Program, including but not limited to the West Virginia Bureau of Medical Services;

   (b) Program. "Program" means, as applicable, a State Medicaid Managed Care Program ("Medicaid"), a state or local Child Health Insurance Program ("CHIP"), a Medicare Advantage program ("Medicare"), a foster care program, a new program borne out of new government regulations, including but not limited to the Accountable Care Act's Health Care Exchanges, or any successor

program to any such Program, and such other federal, state or local program related to, or administered in conjunction with any such Program. Where applicable, "Program" may also refer to any non-governmental health care benefit plan for an individual or group of individuals; and

(c) Program Contract. "Program Contract" means an agreement between Company and Agency which governs the delivery of services, pursuant to a Program, to covered persons including, but not limited to, that certain Service Provider Agreement between the State of West Virginia Department of Health and Human Resources Bureau For Medical Services and Company."

6. The following provision is added to the Agreement as Article IV, Section 4.6:

"Comprehensive Agreement. The Parties shall negotiate in good faith and use all commercially reasonable efforts to duly execute and deliver a comprehensive agreement which shall include the West Virginia specific terms set forth in the Agreement and this First Amendment ("Comprehensive Agreement") by November 1, 2018. The Agreement, as amended by this First Amendment, will terminate concurrent with the effective date of the terms outlined in the Comprehensive Agreement."

7. Article IV section 4.1 of the Agreement is hereby deleted in its entirety and replaced with the following:

"Initial Term. The initial term of this Agreement is for twenty-five (25) months, beginning June 1, 2018 and ending June 30, 2020 ("the Initial Term")." Following the Initial Term, this agreement will renew for successive one year terms unless terminated by either party pursuant to the provisions set forth herein.

8. The following provision is added to the Agreement as Article VI, Section 6.13:

"Assignment. Neither Party may sell, assign, transfer, or otherwise convey any of its rights or delegate any of its duties under this Agreement without the prior written consent of the other Party; provided, however, that either party may without the prior consent of the other Party assign all of its rights and obligations under this Agreement to: (a) its affiliate; (b) a purchaser of all or substantially all of its stock or assets; or (c) a third party participating in a merger or other corporate reorganization in which the assigning party is a constituent corporation. A written notice of such assignment shall be provided to the non-assigning Party. This Agreement will be binding upon and inure to the benefit of the Parties and their respective successors and permitted assigns. Under such assignment, the terms and conditions of this Agreement shall remain in full effect. Any attempted assignment of this Agreement not in accordance with this section shall be null and void."

9. The Compensation Schedule attached hereto as Exhibit C is incorporated into the Agreement.

10. The Regulatory Compliance Addendum attached hereto is incorporated into the Agreement.

11. All other terms and provisions of the Agreement not amended herein shall remain in full force and effect, without modification.

12. The Parties ratify and affirm the Agreement, and agree that it is in full force and effect as amended herein. In the event of any inconsistency between the terms of this First Amendment and the Agreement, the terms of this Amendment shall govern and control.

IN WITNESS WHEREOF, the Parties have caused this First Amendment to be signed by their duly authorized officers.

PROVIDER

By: _____

Printed Name JAMES PURKO

Title: CFO

Date: 8/29/18

COMPANY

By: _____

Printed Name: Todd R. White

Title: Chief Executive Officer

Date: 8-29-18

Exhibit A

REPORTING

a. Monthly Reporting
    a) Members Complaints, Grievances & Appeals
    b) Provider Complaints, Grievances & Appeals
    c) Call Center Operations Data
    d) Aetna Data Warehouse Reports
b. Quarterly Reporting
    a) Provider Adds/Terms
    b) GeoAccess
    c) Credentialing Reporting
    d) Member Grievances & Appeals
    e) Provider Appeals
    f) Mountain Health Trust Reports

Exhibit B

EXHIBIT B-1
CLAIMS ADMINISTRATION SERVICES

A. Delegation. Company maintains full responsibility for all Claims Administration Services, except to the extent such services are specifically delegated to Provider in this section.

B. Delegated Responsibilities. Provider is specifically delegated the following Claims Administration activities for Administrative services:

1. Receive electronic information related to claims for Administrative services.
2. Adjudicate clean claims in accordance with benefit plan rules provided in advance by Company. The parties further acknowledge and agree that:

   a. Claims that do not meet the clean claims standard will be rejected;

   b. Provider may, in its discretion, review and adjudicate claims using automated processes to identify, among other things, potential overpayments and improper billing practices; and

   c. Unless done in coordination with the Program, Provider will not reprocess claims that were adjudicated in accordance with the terms of this Agreement. The foregoing notwithstanding, Provider may, in its discretion, agree to reprocess claims in response to such a request from Company or in its own discretion.
3. Provide notification of claims determinations to Participating Providers and Members, as applicable, in accordance with Regulatory Requirements.
4. Remit payments owed to Participating Providers, as applicable, via electronic funds transfer.
5. Generate and transmit remittance advices and explanation of benefits notices ("EOBs"), as applicable.
6. The claims payment standards outlined in this Agreement do not apply to claims about which there is substantial evidence of fraud or misrepresentation by a Participating Provider or Member, or instances where Provider has not been granted reasonable access to information under the Participating Provider's control. Additionally, Company and Provider are not required to comply with the Medicare or Medicaid terms and conditions of payment if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

C. Company Responsibilities. In addition to maintaining responsibility for those Claims Administration Services not specifically delegated to Provider, Company shall:

1. Require Participating Providers to submit all claims for Administrative services to Provider within the number of days required by Regulatory Requirements following the date Administrative services are rendered. Claims received after this specified time period will be denied for payment.
2. Provide benefit details to Provider on an annual basis (and as necessary if and when benefit details change) at least eight (8) weeks prior to the effective date of such benefit change.
3. Provide Provider with all reimbursement schedules (including revisions to reimbursement schedules) no less than thirty (30) days in advance of the date of service with respect to which they shall become effective.
4. Provide Member eligibility information to Provider in advance of the date for which it is effective. In addition to being delivered prior to the date for which it is effective, membership eligibility information shall be delivered in accordance with the following schedule: (1) a

"full" and complete file -- containing all membership eligibility information -- shall be delivered to Provider on a monthly basis; and (2) a "change" file -- containing additions, deletions, and/or changes to membership eligibility information -- shall be delivered to Provider on a daily basis.

5. Maintain responsibility to receive encounter rejection files and, to the extent it deems appropriate, research, revise, and resubmit such encounters to the State.
6. Communicate Administrative services to Members at least as often as: (a) upon enrollment; (b) once annually, thereafter; and (c) whenever Administrative services change.

EXHIBIT B-2
CONTACT CENTER

A. Delegation. Company maintains full responsibility for all Contact Center activities, except to the extent such activities are specifically delegated to Provider in this section.

B. Delegated Responsibilities. Provider is specifically delegated the following Contact Center activities:

1. Provide dedicated toll-free phone lines for Member inquiries provided on a "warm transfer" from Company and Participating Provider inquiries and a TDD/TTY line for the hearing impaired.
2. Staff Contact Center with trained personnel during traditional business hours of Monday through Friday 8:00 a.m. to 5:00 p.m. Eastern Time (with the exception of National holidays), and to the extent not covered therein, any dates and times mandated by Regulatory Requirements.
3. To the extent set forth in Regulatory Requirements, provide a mechanism for callers to leave a message when calling after-hours and on weekends.
4. Provide translation services to non-English speaking participants.
5. Service Member and Participating Provider inquiries in a professional and courteous manner.
6. Forward Member complaints to the appropriate delegated party if unable to resolve.
7. Forward Participating Provider complaints to the appropriate delegated party if unable to resolve.
8. Maintain all information and records created in connection with performing the delegated duties as necessary to comply with all Regulatory Requirements.

C. Company Responsibilities. In addition to maintaining responsibility for those Contact Center activities not specifically delegated to Provider, Company shall:

1. Advise Provider as soon as practicable regarding any circumstances that may increase the number of inquiries directed to or received by the Contact Center.
2. Service requests for updates to Member PHI.

EXHIBIT B-3
NETWORK DEVELOPMENT AND MAINTENANCE

A. Delegation. Company maintains full responsibility for all Network Development and Maintenance activities, except to the extent such activities are specifically delegated to Provider in this section.

B. Delegated Responsibilities. Provider is specifically delegated the following Network Development activities:

1. Assume responsibility for network development and maintenance including but not limited to recruiting, providing, maintaining and contracting with a network of Participating Providers that is sufficient to comply with Regulatory Requirements. Provider shall be solely responsible for the contracting of the Participating Provider Agreements and shall have sole discretion over the terms and conditions thereof, including all fee schedules, provided that such terms and conditions are in compliance with the Program Contract.
2. Create and maintain an electronic, on-line provider directory via its portal, website, or any other on-line option to be accessed by Company. Provider shall not be required to create, maintain or otherwise support a paper provider directory unless mandated by Regulatory Requirements.
3. Maintain an electronic, on-line provider manual via its portal, website, or any other on-line option with content provided by Company. Provider shall not be required to create, maintain or otherwise support a paper provider manual unless mandated by Regulatory Requirements.
4. Configure claims payment systems for individual Participating Providers and create and maintain reimbursement schedules for each Participating Provider in accordance with Regulatory Requirements.
5. Provider will electronically supply Participating Providers with educational materials, forms and training related to Participating Provider's role and function as mandated by the Program Contract. Provider shall not be required to provide hard copies of educational materials, forms and training unless mandated by the Program Contract.

C. Assignment of Responsibilities. Provider may subcontract with Provider Dental of West Virginia, LLC ("Provider West Virginia") a wholly-owned subsidiary of Provider, for the provision of certain services required of Provider in this Exhibit B-3.

D. Company Responsibilities. In addition to maintaining responsibility for those Network Development and Maintenance activities not specifically delegated to Provider, Company shall:

1. Provide Program specific content for provider manuals.

EXHIBIT B-4
CREDENTIALING SERVICES

A. Delegation. Company maintains full responsibility for all Credentialing activities, except to the extent such activities are specifically delegated to Provider in this section.

B. Delegated Responsibilities. Provider is specifically delegated the following Credentialing activities:

1. Application Verification. At the time a provider is initially credentialed, and when the provider is re-credentialed, Provider shall perform the following tasks:

   a. Secure all provider Credentialing file elements necessary to comply with Regulatory Requirements. The parties acknowledge and agree that Provider may proscribe the manner in which providers submit their credentialing information to Provider, including, but not limited to, proscribing the use of Provider's Credentialing Service.

   b. Primary source verification of all provider Credentialing file elements necessary to comply with Regulatory Requirements from the National Committee of Quality Assurance (NCQA) and/or CMS approved sources for state license verifications, DEA or CDS Certification verifications, education and training verifications, board certification verifications as applicable, malpractice claims history verifications, National Provider Identifier (NPI) number, and state license sanction verifications.

   c. Verify work history (5 years), hospital admitting privileges, and malpractice insurance coverage from NCQA and/or CMS approved sources.

   d. Review of Medicare/Medicaid sanction information for providers through review of the Office of Inspector General (OIG), System for Award Management (SAM) and all published state Medicaid exclusion lists prior to Credentialing and Re-credentialing committee decisions.

   e. Review sanction activity for all individuals named on Disclosure of Ownership (DOO) Forms against the OIG and SAM Exclusions lists.

   f. Maintain credentialing committee minutes that document the discussion and consideration of at least those providers who do not meet established clean file criteria, prior to approval/denial/termination decisions.

   g. Handle Credentialing and/or Re-credentialing decision appeals.

2. Ongoing monitoring. In addition to the foregoing credentialing and recredentialing obligations, Provider will perform the following:

   a. Ongoing monitoring of sanction activity for Participating Providers from state and federal agencies, including the OIG and SAM Exclusions lists, and all published state Medicaid exclusion lists.

   b. To the extent necessary to comply with Regulatory Requirements, ongoing monitoring of sanction activity for all individuals named on DOO Forms against the OIG and SAM Exclusions lists.

C. Company Responsibilities. In addition to maintaining responsibility for those Credentialing activities not specifically delegated to Provider, Company shall:

1. Final authority for approval, suspension, or termination of Participating Providers from participation.
2. Report all Participating Provider terminations as required to state Medicaid agencies.
3. Report practitioner additions to state Medicaid agencies.

EXHIBIT B-5
UTILIZATION MANAGEMENT

A. Delegation. Company maintains full responsibility for all Utilization Management ("UM") activities, except to the extent such activities are specifically delegated to Provider in this section.

B. Delegated Responsibilities. Provider is specifically delegated the following UM activities for Administrative services:

1. Develop clinical criteria to guide UM decisions. The development of clinical criteria shall be billed at the Professional Services rate set forth in Exhibit C.
2. Evaluate medical necessity for those Administrative services that require authorization. In doing so, the parties acknowledge and agree that:
    a. All medical necessity denial decisions will be made by a licensed dentist; and
    b. Provider may, in its sole discretion, use non-dentists to perform Level II reviews for approvals; and
    c. Provider may, in its sole discretion, utilize Post Service/Retrospective, and Pre Service Non-Urgent/Standard Determinations (approval or denial) of specific services.
3. Maintain policies ensuring compensation for Provider employees shall not include any financial incentive for denying Medically Necessary care.
4. Maintain policies describing Participating Provider's right to a peer to peer discussion regarding denial decisions. Peer to peer discussions do not obligate Provider to change a determination, and must take place with a licensed dentist employed by, or contracted with, Provider.
5. Develop communications regarding authorization decisions. The development of such communications shall be billed at the Professional Services rate set forth in Exhibit C.
6. Communicate Member specific authorization decisions to requesting Participating Provider and Member in accordance with Regulatory Requirements.
7. Continuity of care coordination for individual Members.
8. The parties acknowledge and agree that the foregoing UM activities do not include Enhanced Benefit Management services, which are not currently delegated to the Provider.

C. Company Responsibilities. In addition to maintaining responsibility for those UM activities not specifically delegated to Provider, Company shall:

Not applicable.

EXHIBIT B-6
MEMBER COMPLAINTS AND APPEALS

A. Delegation. Company maintains full responsibility for all Member Complaint and Appeal activities, except to the extent such activities are specifically delegated to Provider in this section.

B. Delegated Responsibilities – Member Complaints. Provider is specifically delegated the following Member Complaint activities for Administrative services:

1. Responsibility for Member Complaints
    a. Draft and mail all Member Complaint letters;
    b. Determine whether an extension is clinically needed;
    c. Research, review and determine Complaint outcomes; and
    d. To the extent the Complaint includes clinical language and/or documents, maintain availability of clinicians to respond to such Complaints.

2. Responsibility for Member Complaint Appeals
    a. Draft and mail all Member Complaint Appeal letters;
    b. Determine whether an extension is clinically needed;
    c. Research, review and determine Complaint Appeal outcomes; and
    d. To the extent the Complaint Appeal includes clinical language and/or documents, maintain availability of clinicians to respond to such Complaint Appeal.

3. Responsibility for State Complaints (Inquires/Investigations)
    a. Research support for investigations and respond directly with the Company.

C. Delegated Responsibilities – Member Appeals. Provider is specifically delegated the following Member Appeals activities:

1. Responsibility for Member First Level Appeals – Clinical adverse decision appeals
    a. Draft and mail all Member Appeal letters and appeal rights, as applicable;
    b. As necessary, verbal outreach to Participating Provider (maximum of three attempts) to gather missing information;
    c. Coordinate clinical review of appeal for expedited categorization; and
    d. Determine appeal.

2. Responsibility for Member First Level Appeals – Administrative appeals
    a. Draft and mail all Member Appeal letters and appeal rights, as applicable;
    b. Coordinate administrative review of appeal; and
    c. Determine appeal.

3. Responsibility for Member Second Level Appeals – Clinical adverse decision appeals
    a. Draft and mail all Member Second Level Appeal letters and appeal rights, as applicable;
    b. As necessary, verbal outreach to Participating Provider (maximum of three attempts) to gather missing information;
    c. Coordinate clinical review of Second Level Appeal for expedited categorization; and
    d. Determine Second Level Appeal.

4. Responsibility for Member Second Level Appeals – Administrative appeals
    a. Draft and mail all Member Second Level Appeal letters and appeal rights, as applicable;
    b. Coordinate administrative review of Second Level Appeal; and
    c. Determine Second Level Appeal.

5. Responsibility for participation in Fair Hearing and Independent Review Entity (IRE) appeals procedures as follows:

a. Provider provides support documents/package directly to the Company;

b. Provider shall provide support with clinical representation at hearing. For purposes of the Fair Hearing and IRE, consultant time is billed on an hourly basis as set forth in Exhibit E.

D. Company Responsibilities. In addition to maintaining responsibility for those Member Complaint and Appeal activities not specifically delegated to Provider, Company shall:

1. Provide Provider with Member correspondence templates;
2. Provide translation services (including braille) for all Member correspondence, as applicable; and
3. Schedule Fair Hearing and IRE appeals with State and share scheduling information with Provider in advance of such Fair Hearing.

EXHIBIT B-7

PROVIDER APPEALS AND GRIEVANCES

A. Delegation. Company maintains full responsibility for all Provider Complaint and Appeal activities, except to the extent such activities are specifically delegated to Provider in this section.

B. Delegated Responsibilities – Provider Complaints. Provider is specifically delegated the following Provider Complaint activities:

1. Responsibility for Provider Complaints
    a. Drafting and mailing of all Provider Complaint letters;
    b. Determination whether an extension is clinically needed;
    c. Research, review and determine Complaint outcomes; and
    d. To the extent the Complaint includes clinical language and/or documents, maintain availability of clinicians to respond to such Complaints.

2. Responsibility for Provider Complaint Appeals
    a. Drafting and mailing of all Provider Complaint Appeal letters;
    b. Determination whether an extension is clinically needed;
    c. Research, review and determine Complaint Appeal outcomes; and
    d. To the extent the Complaint Appeal includes clinical language and/or documents, maintain availability of clinicians to respond to such Complaint Appeal.

3. Responsibility for State Complaints (Inquiries/Investigations)
    a. Research support for investigations and respond back to the Company.

A. Delegated Responsibilities – Provider Appeals. Provider is specifically delegated the following Provider Appeals activities:

1. Responsibility for Provider First Level Appeals – Clinical adverse decision appeals (Provider on behalf of Member, where applicable)
    a. Draft and mail all Provider Appeal letters and appeal rights, as applicable;
    b. As necessary, verbal outreach to Provider (maximum of three attempts) to gather missing information;
    c. Coordinate clinical review of appeal for expedited categorization; and
    d. Determine appeal.

2. Responsibility for Provider First Level Appeals – Administrative appeals
    a. Draft and mail of all Provider Appeal letters and appeal rights, as applicable;
    b. Coordinate administrative review of appeal; and
    c. Determine appeal.

3. Responsibility for Provider Second Level Appeals – Clinical adverse decision appeals (Provider on behalf of Member, where applicable)
    a. Draft and mail all Provider Second Level Appeal letters and appeal rights, as applicable;
    b. As necessary, verbal outreach to Provider (maximum of three attempts) to gather missing information;
    c. Coordinate clinical review of Second Level Appeal for expedited categorization; and
    d. Determine Second Level Appeal.

4. Responsibility for Provider Second Level Appeals – Administrative appeals
    a. Draft and mail all Provider Second Level Appeal letters and appeal rights, as applicable;
    b. Coordinate administrative review of Second Level Appeal; and

c. Determine Second Level Appeal.

5. Where permitted by Regulatory Requirements, responsibility for participation in Fair Hearing and Independent Review Entity (IRE) appeals procedures, as follows:

a. Provides support documents/package directly to the Company;
b. Provide support with clinical representation at hearing. For purposes of the Fair Hearing and IRE, consultant time is billed on an hourly basis as set forth in Exhibit E.

B. Company Responsibilities. In addition to maintaining responsibility for those Provider Complaint and Appeal activities not specifically delegated to Provider, Company shall:

1. Provide Provider with Provider correspondence templates;
2. Provide translation services (including braille) for all Member-copied Provider correspondence, as applicable; and
3. Schedule Fair Hearing and IRE appeals with State and share scheduling information with Provider in advance of such Fair Hearing.

Exhibit C
COMPENSATION SCHEDULE

Commencing on the Effective Date of the First Amendment, and through the current term of the Contract, Company shall compensate Provider as follows:

FEES

In consideration of Provider providing the Administrative Services set forth in **Exhibit B** and other obligations of Provider specifically required under the Agreement and First Amendment, Company shall pay Provider the risk-based PMPM Service Fees outlined below, on a per member per month (PMPM) basis; provided that in consideration for the period from June 1, 2018 to the date of execution of this Amendment, the Company shall make a one-time payment to Provider in an amount equal to the difference between the PMPM Service Fee set forth below for such period, minus the agreed upon benefit costs for such period, and any previous compensation paid to Provider for the provision of Services specifically related to such period (the "Catch-Up Payment"). Provider shall invoice the Company for such Catch-Up Payment upon the execution of this First Amendment.

PMPM Service Fees

There shall be one rate structure for Company members as set forth in **Table A-1**.

Table A-1: Service Fees – Medicaid Dental

Membership	PMPM Rate
All Members – under the age of 21	[redacted]

Adjustments to PMPM Service Fees. Following the Initial Term, [redacted]

BILLING

Except for the Catch-Up Payment, on or before the fifteenth (15th) day of a calendar month, Provider shall invoice Company for all Fees for the preceding month:

(i) PMPM Service Fee for the month shall be based upon the number of active Members on the 1st of said calendar month, plus any retroactive Members that have eligibility dates prior to the fifteenth (15th) day of the previous month and not previously invoiced. Any Members added from the fifteenth (15th) to the end of the calendar month shall not be charged any portion of the PMPM Service Fee for that month.

(ii) Company shall be responsible for all fulfillment and postage costs. Such costs will be reflected as a line item on Provider's monthly invoice.

(iii) All invoices should be directed to:

Aetna Better Health of West Virginia
500 Virginia St. East, Suite 400
Charleston, WV 25301

PAYMENT

Payment shall be made by Company via electronic payment to Provider's bank within twenty (20) calendar days of receipt of the invoice from Provider. Payments not received within twenty-five (25) calendar days of receipt of invoice from Provider will be considered late and be charged a late fee equivalent to 12% annually for each calendar day after that 25th calendar day.

Vision Service Plan, Inc. Subcontractor Agreement

WEST VIRGINIA MEDICAID
REGULATORY AMENDMENT TO THE
VISION SERVICES AGREEMENT

This Amendment ("Amendment") is effective September 26, 2016 (the "Effective Date"), and is by and among **Coventry Health Care of West Virginia, Inc.** f/k/a Carelink Health Plans, Inc. and now d/b/a Aetna Better Health of West Virginia ("Aetna-WV") and **Coventry Health Care of Virginia, Inc.** f/k/a Southern Health Services, Inc. and now d/b/a Aetna Better Health of Virginia ("Aetna-VA," and together with Aetna-WV, "Aetna"), on the one hand, and **Vision Service Plan, Inc.** and **VSP Vision Care, Inc.** f/k/a Mid-Atlantic Vision Service Plan, Inc., on the other hand (collectively, "VSP"). Aetna and VSP may each be referred to individually as a "Party" and collectively as the "Parties."

WHEREAS, Aetna entered into a Vision Services Agreement with VSP, effective as of October 1, 2007 (the "Agreement"), for the provision of health care services to, and/or administrative or health-benefit management services/functions relating to, the members of Aetna and/or its affiliates; and

WHEREAS, Coventry Health Care of West Virginia, Inc. f/k/a Carelink Health Plans, Inc., now d/b/a Aetna Better Health of West Virginia and formerly d/b/a CoventryCares of West Virginia, operates and administers a plan in the West Virginia Medicaid market on behalf of the State of West Virginia, and in connection with which Aetna-WV serves as a managed-care organization (the "West Virginia Medicaid Operations"); and

WHEREAS, the Parties desire to amend the Agreement as it relates to the West Virginia Medicaid Operations to include certain additional terms associated therewith.

NOW, THEREFORE, in consideration of the mutual covenants and promises stated herein and other good and valuable consideration, and intending to be legally bound, the Parties agree as follows:

1. The Agreement is hereby amended to add and incorporate in its entirety the Regulatory Compliance Addendum Governing West Virginia Medicaid Services that is attached to this Amendment (the "West Virginia Medicaid Addendum"). VSP agrees to perform its obligations under the Agreement in accordance with the terms and conditions set forth in the West Virginia Medicaid Addendum to the extent that such obligations relate to Aetna-WV and/or the West Virginia Medicaid Operations. In the event of any conflict between the terms of the West Virginia Medicaid Addendum, on the one hand, and any of the other terms of the Agreement, on the other hand, including any other attachments, schedules, exhibits, and/or addenda that are currently appended to the Agreement, the terms of the West Virginia Medicaid Addendum shall govern and control with respect to the provision of services or performance of obligations relating to Aetna-WV and/or the West Virginia Medicaid Operations.

   For the avoidance of doubt, the West Virginia Medicaid Addendum attached hereto shall supersede and replace "Exhibit F – Virginia Medicaid (CareNet) and West Virginia Medicaid Product Guidelines," which is currently appended to the Agreement, but only as such Exhibit F relates to Aetna-WV and/or the West Virginia Medicaid Operations.

2. VSP agrees that all notices required to be sent to Aetna-WV or otherwise directed to Aetna-WV under the Agreement shall be sent to Aetna-WV at the following address in conformity with the notice provisions under the Agreement:

Name	Address	City	State	Zip
Aetna Better Health of West Virginia	500 Virginia St. East, Suite 400	Charleston	West Virginia	25301

3. For the avoidance of doubt, to the extent that the Agreement contemplates the provision of services or performance of obligations unrelated to the West Virginia Medicaid Operations (including without limitation services and/or obligations related to Aetna-VA), the Parties hereby acknowledge and agree that nothing in this

Amendment is intended to amend or modify the Parties' duties, obligations, and liabilities under the Agreement with respect such services or obligations that are unrelated to the West Virginia Medicaid Operations.

4. This Amendment may be executed in one or more counterparts, each of which shall constitute an original and all of which together shall constitute one and the same Amendment.

5. The Parties ratify and affirm the Agreement, and agree that all other terms and provisions of the Agreement not amended herein shall remain in full force and effect, without modification. In the event of any inconsistency between the terms of this Amendment and the Agreement, the terms of this Amendment shall govern and control.

IN WITNESS WHEREOF, the undersigned Parties have executed this Amendment by their duly authorized officers, intending to be legally bound hereby, as of the Effective Date indicated above.

COVENTRY HEALTH CARE OF WEST VIRGINIA, INC. d/b/a Aetna Better Health of West Virginia

Signature

Todd R. White
Printed Name

Chief Executive Officer
Title

3/8/2017
Date

VISION SERVICE PLAN, INC.

Signature

Kate Renwick-Espinosa
Printed Name

President
Title

March 7, 2017
Date

COVENTRY HEALTH CARE OF VIRGINIA, INC. d/b/a Aetna Better Health of Virginia

Signature

Printed Name

Title

Date

VSP VISION CARE, INC.

Signature

Kate Renwick-Espinosa
Printed Name

President
Title

March 7, 2017
Date

VISION SERVICES AGREEMENT

THIS VISION SERVICES AGREEMENT is entered into by and between Vision Service Plan, Inc. and Mid-Atlantic Vision Service Plan, Inc. (hereinafter referred to as **"VSP"**), Southern Health Services, Inc. (**"Southern Health"**), a Virginia corporation and Carelink Health Plans, Inc. (**"Carelink"**), and on behalf of Coventry Health and Life Insurance Company (**"CHLIC"**) and Payors (defined below) (referred to herein collectively as "Health Plans", or individually as stated above) and shall be effective as of the first day of October, 2007. (VSP and Health Plans may be referred to herein collectively as **"Parties"** or individually as a **"Party"**).

WHEREAS, Health Plans and Payors make available to employers and individuals, or administer on behalf of employers or other entities, various health care benefit programs (which may include a vision care service program) for the benefit of employees and their eligible dependents or individual participants and their eligible dependents. In addition, Payors provide administrative services and provider network services to third party administrators, insurance companies offering health benefit plans and insurance companies offering workers compensation coverage plans;

WHEREAS, VSP is a vision care service plan duly authorized to do business in the Commonwealth of Virginia and the State of West Virginia and contracts with licensed vision care specialists (optometrists and ophthalmologists), laboratory facilities and material suppliers in the Commonwealth of Virginia and State of West Virginia to participate in its vision care network (the "VSP Network");

WHEREAS, Health Plans, for themselves and on behalf of Payors, desire to engage the services of VSP to arrange for the provision of vision care services to Members and VSP desires to arrange for the provision of vision care services to such Members through its VSP Network,. Furthermore, participants of the VSP Network shall be listed as VSP Network Providers for Health Plan products;

WHEREAS, VSP, through its VSP Network, agrees to provide Covered Services, as provided herein at the rates hereinafter established pursuant to the terms and conditions set forth below; and

WHEREAS, VSP, upon entering into this Agreement, shall require that VSP Network Providers meet VSP's credentialing requirements, which meet the delegated credentialing requirements set forth in Exhibit C and have been approved by the Health Plans.

NOW, THEREFORE, in consideration for promises and mutual covenants set forth herein and for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Health Plans and VSP hereby agree as follows:

TERMS AND CONDITIONS

I. DEFINITIONS

1.1 **"Administrative Fee"** means the monthly payments made to VSP by or on behalf of Health Plans in consideration of the services performed by VSP under this Agreement.

1.2 **"Authorization"** means the permission issued by VSP identifying the named Member and the Covered Services which the Member is permitted to receive.

1.3 **"Claim"** any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider, to Health Plan, VSP, or their representatives, with which the provider has a provider contract for payment for health care services; however, a "Claim" shall not include a request for payment of a capitation or a withhold.

1.4 **"Claims Amount"** means a Clean Claim for the total negotiated charges between VSP and VSP Network Providers for Covered Services delivered to Members, including, but not limited to, the cost of professional services and ophthalmic materials.

1.5 **"Clean Claim"** unless otherwise required by applicable state law, means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which VSP has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with applicable law.

1.6 **"Consultant Provider"** means a physician or other provider who is not affiliated with VSP, and who may or may not otherwise have a network participation agreement with Health Plans, to whom a Member has been referred to by VSP.

1.7 **"Covered Services"** means those vision care services that VSP shall provide or arrange to provide through its VSP Network to Health Plans' Members pursuant to the applicable Health Benefit Plan.

1.8 **"Emergency Medical Condition"** means a medical condition that manifests itself by symptoms of sufficient severity or 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: (i) serious jeopardy to the mental or physical health of the Member, (ii) danger of serious impairment of the Member's bodily functions, (iii) serious dysfunction of any of the Member's bodily organs, or (iv) in the case of a pregnant Member, serious jeopardy to the health of the fetus.

1.9 **"Emergency Vision Services"** means those inpatient or outpatient Covered Services that (i) are furnished by a provider qualified to furnish such services; (ii) needed to evaluate or stabilize an Emergency Medical Condition.

1.10 **"Entire Agreement"** means this Vision Services Agreement, the Provider Manual, any addenda, attachment, schedule or exhibit, and any policies or procedures otherwise made a part of this Agreement by attachment. The Entire Agreement shall also include any stated and adopted amendments made pursuant to this Agreement. These documents constitute the entire understanding of the Parties with respect to the subject matter and supersede any prior agreements between the parties.

1.11 **"Health Benefit Plan"** means the eligibility, requirements, procedures, Covered Services, benefits, conditions, limitations, exclusions, and other rights and obligations governing payment for health services furnished to Members pursuant to this Agreement and a particular product. A written description of the Health Benefit Plans which are offered and/or financed by Health Plans and Payors will be supplied to VSP.

1.12 **"Medically Necessary"** means the use of services or supplies as provided by a hospital, skilled nursing facility, physician or other provider required to identify or treat a Member's illness, injury or pregnancy-related condition, and which, as determined by Health Plans or VSP are: (i) consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury; (ii) appropriate with regard to standards of good medical practice; (iii) not solely for the convenience of the Member, his/her VSP Network Provider, hospital, or other health care provider; and (iv) the most appropriate supply or level of service which can be provided safely to the Member.

1.13 **"Member" or "Enrollee"** means an individual who is eligible to receive Covered Services under one of Health Plans' Member Contracts. Member includes the subscriber, and any of the subscriber's eligible dependents. Member/Enrollee may be used interchangeably throughout this Agreement.

1.14 **"Member Contract"** means the group or individual Evidence of Coverage, Certificate of Insurance, Subscription Agreement, plan document, employer group agreement, or other contract as amended from time to time between Health Plans or a Payor and an employer, union, association, other type of group of individuals, or Member, which sets forth the terms of the health benefit plan coverage.

1.15 **"Payor"** means an entity authorized by Health Plans to access one or more networks of VSP Network Providers, including the VSP Network, and who or which is liable for funding or underwriting benefit payments under a Member Contract, which entity has a financial responsibility to pay for Covered Services rendered to Members. Payor may include Health Plans, insurers, auto insurance carriers, employers, unions and other entities.

1.16 **"Provider Manual"** Health Plans' manuals, policies, and procedures that are applicable to participating providers and subcontractors.

1.17 **"VSP Network Provider"** An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Members.

II. OBLIGATIONS OF VSP

2.1 **Services, Generally.** As more particularly set forth herein, VSP shall administer for Health Plans a vision care services product through its VSP Network as of the effective date stated above, except that for the Carelink Advantra Medicare health benefit plans, VSP shall administer a vision care services product effective January 1, 2008 (See Exhibit G). VSP understands and agrees that Health Plans will offer a variety of Health Benefit Plans that will include a vision care component through VSP in which members of the VSP Network will be considered participating providers. Health Plans reserve the right to determine which Health Benefits Plans will include VSP's vision care services. VSP shall not require that all Payors on whose behalf Health Plans enter into this Agreement provide vision care services through this Agreement.

2.2 **Delegated Functions.** VSP shall perform all claims processing and payment, quality assessment, credentialing and re-credentialing, and other delegated functions as set forth in Exhibit C. None of the vision care services products, described more fully in Exhibit B, shall contain pre-authorization requirements

2.3 **Vision Network.** VSP shall, at all times, maintain contracts ("Participation Agreements") with a sufficient number of VSP Network Providers to guarantee its ability to deliver Covered Services to Health Plans' Members as described herein. Such Participation Agreements shall comply with all applicable state and federal regulations. At least once a year, and upon request, VSP shall provide or make available to Members a copy of the most current VSP Network directory listing or Members may obtain information on VSP's Network Doctors through VSP'S Web site at **vsp.com** or our Customer Service Department's toll-free number 800.877.7195.

2.4 **Covered Services.** VSP shall arrange through its VSP Network Providers for Members to access Medically Necessary Emergency Vision Services twenty-four (24) hours a day/seven (7) days a week, within the VSP Network. VSP shall require VSP Network Providers to make available non-emergency Covered Services at least five (5) days a week during reasonable business hours. In the event VSP does not have a VSP Network Provider available to render Covered Services to a Member, VSP shall make a referral to a Consultant Provider. All Covered Services

rendered by such Consultant Provider shall be rendered in accordance with this Agreement.

2.5 **Discrimination Prohibited.** VSP shall not, and shall require that VSP Network Providers shall not differentiate or discriminate in the treatment of Members by reason of age, race, color, creed, religion, gender, sexual preference, national origin, health status, use of Covered Services, income level, or on the basis that Member is enrolled in a managed care organization or is a Medicare or Medicaid beneficiary. VSP further agrees, and shall require VSP Network Providers to agree, to provide Covered Services to Members in accordance with the same standards and within the same time availability as provided to other patients. This Section shall not prevent VSP or a VSP Network Provider from terminating the provision of care of any Member, so long as this decision is based on the same criteria that VSP or VSP Network Provider uses for all patients and is not based on the fact that the patient is a Member.

2.6 **Network Provider Responsibility.** VSP agrees that VSP Network Providers shall be solely responsible for all medical advice provided and treatment rendered to Members, and for the performance of all Covered Services required under this Agreement and the Participation Agreement. All Covered Services shall be provided in conformity with accepted medical and surgical practices and shall meet or exceed the standard of care. VSP agrees, and shall require all VSP Network Providers to agree, that all professional decisions, judgments, treatments, diagnoses, other professional services VSP Network Providers render to Members, and the maintenance of such VSP Network Provider's relationship with a Member are the VSP Network Provider's sole responsibility. Health Plans will not, and VSP agrees that it shall not, exercise control or direction over, nor will it be liable for, the manner or method by which a VSP Network Provider renders professional services to Members under this Agreement and its Participation Agreement. VSP shall communicate to its VSP Network Providers that they can and must freely communicate with Members regarding appropriate treatment alternatives and/or the treatment options available to them, including alternative medication, regardless of benefit coverage limitations. Health Plans are entitled to deny payment to VSP, and VSP is entitled to deny payment to VSP Network Providers for services rendered to a Member that are not Covered Services, or that are not otherwise rendered in accordance with this Agreement or the applicable Participation Agreement. A coverage denial does not absolve a VSP Network Provider, however, of his/her/its Provider's professional responsibility to provide appropriate medical care to Members.

2.7 **Collection of Cost-Sharing Amounts.** VSP shall require its VSP Network Providers to collect any copayments, coinsurance or deductibles for Covered Services provided to Members in accordance with this Agreement, the Participation Agreement, and the applicable Health Benefit Plan. VSP shall not, and VSP shall cause its VSP Network Providers to not, discount or waive any required copayments, coinsurance or deductibles.

2.8 **Compliance with Agreement.** VSP shall, and shall require its VSP Network Providers to participate in and comply with the requirements of this Agreement and the Provider Manual, as they may be amended and supplemented by Health Plans from time to time. VSP shall, and shall require its VSP Network Providers to comply with all final determinations rendered by any programs or procedures included as part of the Agreement. In the event any documents that are part of the Agreement directly contradict each other, the document with the latest revision date shall supersede.

2.9 **Maintenance of Records.**

2.9.1 Health Plans and VSP agree that all medical records of Members shall be treated as confidential so as to comply with all applicable federal and state laws regarding the confidentiality of patient records. VSP shall, and VSP shall require its VSP Network Providers to, make records available to Health Plans at no cost to either Health Plans or Member. Such records shall include identifying patient information, medical histories, and financial, administrative, and other records relating to (i) the provision of Covered Services; (ii) the cost of these services; and (iii) payments received by VSP and/or VSP Network Provider from Member. VSP shall be responsible and/or shall require that its VSP Network Providers be responsible for obtaining Members' authorization(s), in the form required by law, both to allow the record examination and to allow VSP's and/or VSP Network Provider's release of any information contemplated under this Agreement or a Health Benefit Plan. The parties agree that such records shall at all times retain the same confidential status accorded these records while in possession of VSP or a VSP Network Provider. The obligations of the parties as set forth in this paragraph shall survive any termination or expiration of this Agreement.

2.9.2 VSP shall prepare and maintain, and shall require VSP Network providers to prepare and maintain, for each Member receiving Covered Services pursuant to this Agreement a standard service record in such form, containing such information, and retained for such time as required by the applicable federal and state laws and licensing requirements and professional standards governing the provision of the Covered Services, and in accordance with any special requirements that may be enacted by Health Plans which are not in conflict with applicable federal and state requirements. VSP shall and VSP shall cause its VSP Network providers to participate in a system established by Health Plans which facilitates the maximum sharing of such records, equipment, and professional, technical, and administrative staff for Health Plans' Utilization Management/Quality Improvement Program, subject to federal and state laws and professional standards governing the confidentiality of medical records.

2.10 **Access to Records and Facilities.**

2.10.1 VSP shall permit Health Plans or its designated representatives access to VSP's facilities and billing or medical records at a reasonable time convenient for the Parties. Moreover, VSP shall require VSP Network Providers to permit Health Plans and/or VSP access to facilities and billing or medical records for assurance that such facilities and records are in keeping with generally accepted standards, manufacturer's standards, or standards which may be established by Health Plans and/or VSP.

2.10.2 VSP shall make, and shall require VSP Network Providers to make, their books and records relating to Members and the Covered Services provided hereunder, or relating in any way to Health Plans available to any state or federal agencies as required pursuant to such agencies' legal authority.

2.11 **Compliance with Law.**

2.11.1 VSP warrants that it shall comply, and shall require VSP Network Providers to comply with all applicable local, state, and federal laws. VSP shall maintain, and shall require VSP Network Providers to maintain all necessary and required licenses, permits, accreditations and certifications. All employees of VSP and/or VSP Network provider shall perform their duties in accordance with all applicable local, state, and federal licensing requirements, as well as national, state, and county standards of professional ethics and practices, as may be applicable. The VSP Network Doctor Agreement stipulates that the doctor notify VSP immediately in the event of any such occurrences whereby VSP also acts immediately by terming the doctor, thus removing him/her from seeing patients. VSP shall notify Health Plans within forty eight (48) hours of such occurrence.

2.11.2 VSP shall require that VSP Network Providers employ or contract with only those personnel who hold a current and effective license or certification to practice their respective professions in the respective state, provided a license or certificate is applicable. VSP shall also require its VSP Network Providers to utilize an appropriate credentialing process for such employees.

2.12 **Insurance.**

2.12.1 VSP shall procure and maintain, and VSP shall require its VSP Network Providers to procure and maintain, at their respective sole expense, professional liability and malpractice, as well as comprehensive general liability insurance and other insurance containing such provisions as shall be required by state law. Such insurance shall be in an amount as shall be necessary to insure VSP and/or VSP Network Providers and their respective employees or agents against any claim or claims for damages

arising by reason of personal injury or death occasioned directly or indirectly in connection with the provision of any services by such party or its/their employees or agents, the use of any property and facilities provided by such party or its/their employees or agents, and the activities performed by such party or its/their employees or agents in connection with this Agreement, or as may be required under state law, whichever is greater. VSP shall require VSP Network Providers to procure and maintain such insurance for themselves and other health care professionals employed or under contract with such provider unless they are covered under insurance policies of VSP or the VSP Network Provider.

2.12.2 VSP shall notify Health Plans in writing thirty (30) days prior to any denial of, restriction on, or termination of VSP's or a VSP Network provider's general or professional liability insurance, except where such insurance is immediately replaced by equivalent insurance not subject to such denial, restriction, or termination.

2.12.3 VSP shall notify Health Plans, and shall require VSP Network Providers to notify VSP, of any tort claims, whether relating to a Health Plans' Member or another patient, filed against the VSP and/or the VSP Network Provider within five (5) business days of receipt of notice of such a claim having been filed. VSP shall provide, and VSP shall require VSP Network Providers to provide Health Plans with any information related to such claim(s) that is reasonably requested by Health Plans. In addition to the information required by this Section 2, VSP shall submit to Health Plans, and VSP shall require VSP Network Providers to submit upon VSP or Health Plans' request, any additional information on tort claims involving VSP and/or a VSP Network Provider, when necessary to enable Health Plans to comply with applicable state or federal law.

2.13 **Encounter Data.** VSP shall maintain and provide in a form acceptable to Health Plans, no later than the tenth (10th) day of each month, the encounter data pertaining to Covered Services which are provided, arranged, or paid for by VSP during the preceding month, including data not provided in the most recent submission. Such encounter data includes all Covered Person-specific encounter data reasonably required by HMO to conduct utilization review and to comply with all reporting requirements of Governmental Agencies

2.14 **Cooperation with Health Plans.** VSP shall cooperate with Health Plans in the event of a Market Conduct or other regulatory audit, inspection or review. VSP shall be responsible for indemnifying Health Plans pursuant to Section 5.8 below for any fines, penalties, or settlement amounts imposed upon Health Plans for errors, wrongdoing, or non-compliance, directly or indirectly, related to VSP's performance or non-performance. VSP shall not distribute to Members any forms or materials without first submitting such forms or materials to Health Plans for approval. If required by state or federal law, Health Plans will file the forms or

material, on VSP's behalf, with the appropriate regulatory agencies and receive all requisite approvals prior to issuing Health Plans' approvals to VSP and prior to VSP's use of these forms or materials. This Section 2.14 shall survive the termination of this Agreement for a period through the end of any potential retroactive audit period.

III. OBLIGATIONS OF HEALTH PLANS

3.1 **Information Provided by Health Plans.** Health Plans shall provide VSP with the management information, enrollment and eligibility data, and other information reasonably necessary for VSP to carry out the terms and conditions of this Agreement.

3.2 **Member Eligibility Data.** On a weekly basis, Health Plans shall provide to VSP a Member eligibility listing for all Members in all of Health Plans' Health Benefit Plans covered under this Agreement. Health Plans shall not be financially responsible for the Administrative Fee or Claims Amounts for services rendered to persons who are not listed as eligible but to whom a VSP Network Provider rendered services. These services shall be considered uncovered. However, Health Plan agrees to pay to VSP the cost for covered services provided to an ineligible covered person listed as eligible subject to reimbursement for any payment VSP may recover from a third part for such services. Health Plans shall provide VSP reasonable access to all books, records, and documents relating to the determination of a Member's eligibility.

3.3 **Member Materials.** Health Plans shall distribute to Members any disclosure forms, plan summaries, or other materials required to be distributed under state or federal law. Health Plans shall be responsible for distributing vision plan enrollment and marketing materials to Members upon enrollment, renewal, and open enrollment periods. Health Plans shall provide such information to Members concerning the type, scope, and duration of benefits to which Members are entitled under their Health Benefit Plans. Health Plans agree that any materials developed for Members related to vision benefits must be approved by VSP prior to dissemination, such approval not to be unreasonably withheld

3.4 **Benefit Plan Design.** Health Plans shall be solely responsible for vision benefit design for the Health Benefit Plans, and shall direct VSP to administer such plans accordingly.

3.5 **Grievance, Complaints and Appeals.** Health Plans shall be responsible for receiving, handling, and responding to, Member grievances, complaints and appeals in accordance with their policies and procedures. In the event VSP receives a grievance, complaint or appeal from a Member or a VSP Network Provider, VSP shall send such grievance, complaint or appeal to Health Plans within twenty-four (24) hours.

3.6 **Compliance with Law.** Health Plans shall at all times comply with state and federal law, including but not limited to, the Ethics and Fairness in Carrier Business Practices Act in Virginia and/or the Fair Business Practices Act in West Virginia, as set forth in Exhibit E and Exhibit D.

IV. QUALITY IMPROVEMENT

4.1 VSP shall provide reporting as required by Health Plans to comply with HEDIS® requirements and quality improvement activities necessary to maintain compliance with Health Plans accreditation standards (NCQA, URAC, etc.) and/or state and federal law and as may be mutually agreed by the parties. Reporting will be no less than semiannual. Areas of specific reporting would be: provider accessibility/availability, adverse/sentinel events, and any collaborative quality improvement activities. Health Plans shall have the right to conduct audits annually to assure compliance with said agreements.

V. COMPENSATION AND FISCAL RELATIONSHIPS

5.1 **Payment of Administrative Fee.** On or before the twentieth day of each month, Health Plans shall remit to VSP an Administrative Fee as outlined in Exhibit A. In the event that Health Plans do not pay the Administrative Fee in accordance with this Section 5.1 and Exhibit A, a grace period of thirty-one (31) days following the due date of the Administrative Fee shall be offered during which time the Agreement and Covered Services to be delivered by VSP Network Providers shall remain in full force and effect for all Members.

5.1.1 **Enrollment Adjustments.** With each monthly Administrative Fee, Health Plans shall make adjustments to reflect corrections (additions or deletions) made to Health Plans enrollee enrollment data. The parties understand and agree that retroactive adjustments to capitation payments shall be limited to the lesser of: (i) the actual retroactive adjustment; or (ii) ninety (90) days. Such adjustments shall be reconciled no later than 90 days after the month in question. Whether an Enrollee is enrolled in a product shall be measured as of the 15th of the month in question.

5.2 **Payment of Claims Amount.** On a monthly basis, VSP shall provide to Health Plans a complete electronic data file to support the Claims Amount, including the following information: Member name, Member ID number, date of service, VSP Network Provider name, CPT codes, billed amount, allowed amount, amount paid to VSP Network Provider by VSP. Based on the monthly invoice and electronic data file submitted to the Health Plans, the Health Plans shall reimburse VSP the Claims Amount within 31 days of receipt.

5.3 **Right to Renegotiate:** VSP may change the Administrative Fees set forth in Exhibit B (Schedule of Administrative Fees) by giving HMO at least sixty (60) days

advance written notice. No change will be made during the plan term unless there is a change in the Schedule of Benefits or there is a material change in plan terms or conditions, provided any such change is mutually agreed upon in writing by VSP and Health Plan.

5.4 **Coordination of Benefits.** VSP shall require VSP Network Providers to assist in coordination of benefits, as may be applicable.

5.5 **Non-Billable Services.** VSP shall not, and shall require VSP Network Providers to not, bill additional amounts because goods or services are provided outside of a VSP Network Provider's posted business hours. Charges that may not be billed without Health Plans' express permission include but are not limited to fees for completing claim forms, fees for making copies of records requested or other fees for submitting additional information requested. VSP agrees, and shall require VSP Network Providers to agree, that neither Health Plans nor the Member has any obligation to pay VSP or a VSP Network Provider for services undocumented in the patient record or not sufficiently documented.

5.6 **Indemnification.** VSP shall defend, indemnify, and hold harmless, Health Plans and their directors, officers, employees, affiliates, and agents against any claim, loss, damage, cost, expense, or liability arising out of or related to the performance or nonperformance by VSP, its employees, agents, or assigns. of any responsibilities or obligations under this Agreement. VSP represents and warrants that it requires each VSP Provider to: (i) maintain professional liability (malpractice) insurance coverage in an amount not less than $1,000,000 per occurrence and $3,000,000 annual aggregate; (ii) maintain general liability coverage in an amount not less than $1,000,000 for money owed for Covered Services, except any copayments, coinsurance, or other fees stated in the Member's benefit plan or fees related to vision care services which are not Covered Services. Health Plans shall defend, indemnify, and hold harmless VSP and their directors, officers, employees, affiliates, and agents against any claim, loss, damage, cost, expense, or liability arising out of or related to the performance or nonperformance by Health Plans, their directors, officers, employees, agents, of any responsibilities or obligations under this Agreement.

TERM AND TERMINATION

6.1 **Term.** The term of this Agreement shall commence on the effective date stated above and shall be effective [for a period of one (1) year] (the "Initial Term"). Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless and until terminated in accordance herewith. After the Initial Term, either party may terminate this Agreement without cause by giving the other party at least [ninety (90)] days' prior written notice to the other or as otherwise provided herein.

6.2 **Termination For Cause.**

6.2.1 **Breach**. Either Party may terminate the Agreement for the breach of a material term, condition or provision of the Agreement, after sixty (60) days prior written notice to the other Party, specifying such material breach. The breaching Party shall have a minimum of thirty (30) days or such longer reasonable period agreed to by the Parties to correct or cure such material breach. If the breaching Party fails or refuses to cure the material breach within such time, then the non-breaching Party may elect to terminate the Agreement effective the last day of the month following the end of the notice period. The remedy herein provided shall not be exclusive of, but shall be in addition to, any remedy available at law or in equity to the non-breaching Party. In the event a party contests the claim of breach, the Agreement shall remain in effect until the dispute is resolved in accordance with Section 8.8 herein.

6.2.2 **Immediate Termination by Health Plans**. Health Plans may terminate this Agreement for the following reasons:

6.2.2.1 Termination, revocation, suspension or other limitation of VSP's license, certification, or accreditation, or participation in Medicare and/or Medicaid.

6.2.2.2 Termination of VSP's Professional Liability Insurance.

6.2.2.4 Conviction of, or plea of no contest to, a felony or any criminal charge relating to health care delivery.

6.2.2.5 Health Plan determines in good faith that VSP's continued provision of services to Members may result in, or is resulting in, danger to the health, safety or welfare of Members. Where the danger results from the actions of VSP's staff, VSP Network Providers, or other contractors or subcontractors, then VSP shall suspend its relationship with such VSP Network Providers, staff, contractors, or subcontractors upon immediate notice from Health Plans, at least with respect to Members, and if VSP fails to take such action, Health Plans may terminate the Agreement upon ten (10) days notice to VSP. Health Plans may specifically request VSP terminate a VSP Network Provider based upon reasons set forth in this Section 6.3.2.5.

6.3 **Run-Out Period After Termination**. Upon termination of the Agreement, and for a period of three-hundred and sixty-five (365) days thereafter, VSP agrees to process claims from VSP Network Providers related to Covered Services rendered to Members during the term of the Agreement pursuant to the applicable terms and conditions set forth herein, and pursuant to applicable state or federal law. Health Plan shall be responsible for the cost of the claims incurred by members on a monthly basis within (ten)10 days of receipt of billing statement.

6.4 **Records Provided Upon Termination.** Upon termination of the Agreement, Health Plans reserve the right to request VSP to produce, and to require VSP Network Providers to produce, to Health Plans, or a designee, copies of all Member files in the possession of VSP and/or VSP Network Providers. The files may be in summary form upon approval from Health Plans.

6.5 **Termination by VSP Network Providers.** VSP shall require in its Participation Agreement that VSP and VSP Network Providers must give no less than ninety (90) days written notice prior to terminating such Participation Agreements.

VI. DELEGATED FUNCTIONS

7.1 **Credentialing.** VSP shall have sole responsibility for credentialing and recredentialing all VSP Network Providers pursuant to its standards and policies which shall comply with applicable state law and accreditation requirements. VSP agrees, and shall require all VSP Network Providers to agree that VSP Network Providers have training and experience required by VSP, in accordance with accreditation standards, in the field in which they provide services, and that ophthalmologists shall be Board Certified or Board Eligible in their specialties, or qualified by virtue of previous training or experience. VSP has established policies consistent with NCQA standards. Credentialing shall be performed under this Agreement in accordance with Exhibit C. Upon request from Health Plans, VSP shall make its credentialing and recredentialing files available to Health Plans. In addition, upon request, VSP shall provide to Health Plans a list of all VSP Network Providers, in the format requested by Health Plans.

7.2 **Claims Processing and Payment.** Health Plans shall delegate claims processing functions to VSP. VSP shall at all times comply with the Ethics and Fairness in Carrier Business Practices Act in Virginia and/or the Fair Business Practices Act in West Virginia, as set forth in Exhibit E and Exhibit D in its relationships with and obligations to VSP Network Providers.

7.3 **Additional Delegated Functions.** Exhibit C sets forth additional functions that will be delegated to VSP by Health Plans.

VII. GENERAL PROVISIONS

8.1 **Notice.**

8.1.1 Any notice required or permitted to be given pursuant to the terms of this Agreement shall be in writing and shall be sent by registered or certified mail, return receipt requested, by regular mail, or by hand delivery, addressed to each party at the address set forth below. Such

notice may reference an Internet site for an actual amendment where it would be reasonable for Health Plans to expect that VSP has access to the Internet site. Such notice shall be effective, with respect to mailing, three (3) business days after being delivered, properly addressed and postage prepaid to any branch of the United States post office and with respect to hand delivery, upon receipt.

To VSP:	**To Health Plans:**
[ADDRESS]	Southern Health Services, Inc. Attn: Vice President of Network Operations Town Center One 1000 Research Park Blvd. Charlottesville, VA 22911

8.1.2 VSP shall notify Health Plans within seven (7) days of any changes to information previously provided to Health Plans regarding itself or a VSP Network Provider. VSP shall, on an quarterly basis, or as more frequently requested by Health Plans, provide Health Plans with a list of current VSP Network Providers who have executed a contract with a VSP and who are anticipated to provide Covered Services to Members in accordance with this Agreement. Such list shall include the names and localities of the VSP Network Providers.

8.2 **Independent Entities.** None of the provisions of the Agreement is intended to create, nor shall be deemed or construed to create any relationship between the Parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of the Agreement. Neither VSP nor Health Plans nor any Payor shall be liable to any other Party for any act, or any failure to act, of the other Party to the Agreement.

8.3 **Cooperation Between Parties.** Health Plans and VSP agree that, to the extent compatible with the separate and independent management of each, they shall at all times maintain an effective liaison and close cooperation with each other in order to provide and/or arrange for the provision of Covered Services to Members at the most reasonable cost, consistent with high standards of medical care. The parties shall endeavor at all times freely and fully to exchange information regarding all matters directly or indirectly related to areas of common interest, except that neither party shall be required to exchange information to the extent that any such exchange of information is not permitted by law to the extent compatible with the separate and independent management of each.

8.4 **Amendments.** No amendment to this Agreement, or to the Participation Agreements between VSP and VSP Network Providers, or to any addenda, schedule, exhibit or policy thereto, or to the range of Covered Services reasonably expected to be delivered by VSP or VSP Network Providers, shall be effective as to VSP or VSP Network Providers, unless Health Plans have provided VSP, or VSP

has provided VSP Network Providers, the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least sixty (60) calendar days before the effective date, and VSP has failed to notify Health Plans, or VSP Network Provider has failed to notify VSP, within thirty (30) calendar days of receipt of the documentation of their intent to terminate this Agreement or the Participation Agreement, at the earliest date thereafter permitted by the applicable agreement.

8.5 **Assignment.** This Agreement, being intended to secure the services of VSP shall not in any manner be assigned, subcontracted, delegated, or transferred by VSP without the prior written consent of Health Plans. Health Plans shall have the absolute right and sole discretion, to assign or license all or any of its rights and responsibilities and delegate all or any of its obligations, under this Agreement (i) to any corporation that controls, is controlled by, or is under common control with Health Plans; (ii) to any successor to the business of Health Plans whether by merger, consolidation, sale of assets, operation of law or otherwise; or (iii) to Coventry HealthCare Management Corporation.

8.6 **Effect of Agreement.** Upon the Effective Date of this Agreement, this Agreement shall supersede all prior documents, representations and understandings of the parties which may relate to the subject matter of this Agreement, including but not limited to, any agreement currently in place between VSP and Health Plans, any portion of the Provider Manual or any other of Health Plans' policies and procedures. No other understanding, except as described below in this Section 8, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or bind either party. Subsequent changes to the Provider Manual or Health Plans's policies and procedures, or any amendments, exhibits or schedules may override provisions of this Agreement; however, no amendment to any part of the Entire Agreement shall cause this Agreement to fall into non-compliance with applicable state or federal law.

8.7 **Entire Agreement.** Health Plans warrants that at the time this Entire Agreement is presented to VSP for execution (i) the compensation terms, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to VSP or to the range of vision care services reasonably expected to be delivered by VSP or its VSP Network providers on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in Section 8 applicable to VSP or to the range of vision care services reasonably expected to be delivered by a VSP Network Provider under this Agreement will be included as part of this Agreement.

8.8 **Dispute Resolution.** In the event a dispute between Health Plans and VSP arises out of or is related to the Agreement, the Parties involved shall make good faith efforts to settle the dispute by negotiation between the Parties. If negotiation between the Parties is unable to resolve a dispute within (thirty) 30 days of the date the aggrieved party sends written notice of the dispute to the other Party, and if any

Party wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the commercial rules of the American Health Lawyers Association or other nationally recognized alternative dispute resolution association mutually acceptable to the Parties. Any arbitration proceeding under the Agreement shall be conducted in Richmond, Virginia. The arbitrators shall have no authority to award any punitive or exemplary damages, or to vary or ignore the terms of the Agreement, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain of Health Plans' procedures, such as, for example, utilization management or quality improvement plan (but not including credentialing procedures), the procedures set forth in that plan must be fully exhausted before any right to arbitration under this Section may be invoked. Notwithstanding the foregoing, neither Party shall be precluded from seeking injunctive or other equitable relief in court in connection with the enforcement of those sections of the Agreement that permit actions for injunctive relief. Except for such relief expressly contemplated by the Agreement, any dispute arising out of the Agreement must be submitted to binding arbitration and jurisdiction shall not be found in a court of law. This Section shall survive termination of the Agreement.

8.9 **Confidentiality.** VSP and Health Plans and Payors agree to maintain the privacy and confidentiality of all information and records regarding Members, including but not limited to medical records, in accordance with all State and Federal laws, including regulations promulgated under the Health Insurance Portability and Accountability Act. In addition, each Party shall maintain the confidentiality of the financial terms of the Agreement and the confidentiality of the other Party's proprietary information that is not otherwise public information, provided Health Plans or a Payor may disclose reimbursement terms to prospective and current employer groups and provided all parties may disclose information as required by state or federal laws or regulations. VSP 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. In the event that either Party violates its duties under this provision, the other Party may seek injunctive relief. This Section shall survive the termination of the Agreement.

8.10 **Waiver.** The waiver of either party of a breach or violation of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach thereof.

8.11 **Applicable Law.** This Agreement shall be governed in all respects by the laws of the Commonwealth of Virginia. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other terms or provisions.

IN WITNESS WHEREOF, the parties have duly executed this Agreement on the day and year written below.

SOUTHERN HEALTH SERVICES, INC.

By: Cosby M. Davis III

Print Name: Cosby M. Davis III

Title: President + CEO

Date: 04-10-08

VISION SERVICES PLAN, INC.

By: _____

Print Name: Gary Brooks

Title: Vice President/Secretary

Date: April 10, 2008

CARELINK HEALTH PLANS, INC.

By: Cosby M. Davis III

Print Name: Cosby M. Davis III

Title: President + CEO

Date: 4-10-08

MID- ATLANTIC VISION SERVICE PLAN

By: _____

Print Name: Gary Brooks

Title: Vice President/Secretary

Date: April 10, 2008

EXHIBIT A
SUMMARY OF BENEFITS AND RATES

12312944 (Southern Health) Division Name	Division	Class	Plan Description	Frequency	Copay	Retail Frame Allowance	Contact Lens Exam	Contacts Allowance	OON Allowance	Rate
City of Richmond 9620	0002	0001	Exam + with allowance	12/12/12 Plan year						
9600 & 9630	0004	0004	Exam +	12 Service Year						
9605, 9627, 9631 & 9636	0006	0006	Exam +	12 Service Year						
9606 & 9633	0008	0008	Exam +	12 Service Year						
9607, 9608, 9634, & 9635,	0010	0010	Exam +	12 Service Year						
New Crutchfield Value Plan 9641	0012	0012	Exam +	12 Service Year						

New Critchfield HDHP Plan 9642	0014	0014	Exam +	12 Service Year						
9609 (SL Williamson)	0016	0016	Signature	12/12/12 Service Year						
9601 Customized Essential Plan	0020	0020	Signature	12/12/12 Service Year						
9602 Customized Standard lan	0022	0022	Signature	12/12/12 Service Year						
9643	0024	0024	Exam + with allowance	12/12/12 Plan year						
12301728(CareLink) Division Name	Division	Class	Plan Description	Frequency	Copay	Retail Frame Allowance	Contact Len Exam	Contacts Allowance	OON Allowance	Rate
8326	0006	0006	Exam + with allowance	12/12/12 Service Year						
8333	0008	0008	Exam + with allowance	12/12/12 Service Year						
8327 & 8382	0010	0010	Exam + with allowance	12/12/12 Service Year						
8328 & 8383	0012	0012	Exam + with allowance	12/12/12 Service Year						
329 & 384	0014	0014	Exam + with allowance	12/12/12 Service Year						

8330 & 8385	0016	0016	Exam + with allowance	12/12/12 Service Year						
8331 & 8386	0018	0018	Exam + with allowance	12/12/12 Service Year						
8332 & 8387	0020	0020	Exam + with allowance	12/12/12 Service Year						
8345	0022	0022	Exam + with allowance	12/12/12 Service Year						
8322	0024	0024	Exam + with allowance	12/12/12 Service Year						
8323	0026	0026	Exam + with allowance	12/12/12 Service Year						
8324	0028	0028	Exam + with allowance	12/12/12 Service Year						
8325	0030	0030	Exam + with allowance	12/12/12 Service Year						
12318445 CareNet Division Name	**Division**	**Class**	**Plan Description**	**Frequency**	**Copay**	**Retail Frame Allowance**	**Contact Len Exam**	**Contacts Allowance**	**OON Allowance**	**Rate**
Children Ages 0-20	0002	0002	Medicaid with PEC	24/24/24 Service Year						
Adults Age 21 & over	0004	0004	Medicaid with PEC	24/24/24 Service Year						
Famis-Age 19 and Under	0006	0006	Medicaid with PEC	24/24/24 Service Year						
12318127 CareLink Medicaid Division Name	**Division**	**Class**	**Plan Description**	**Frequency**	**Copay**	**Retail Frame Allowance**	**Contact Len Exam**	**Contacts Allowance**	**OON Allowance**	**Rate**
Children Ages 0-20	0002	0002	Medicaid with PEC and GAP	12/12/12 Service Year						

12318972 CareNet Discount Plan Division Name	Division	Class	Plan Description	Frequency	Copay	Retail Frame Allowance	Contact Len Exam	Contacts Allowance	OON Allowance	Rate
CareNet Discount Plan	0002	0001	Straight Access	1 day						

PLAN DESCRIPTION:

1. Exam + with allowance-The Exam Plus with Allowances Plan provides a comprehensive exam benefit covered in full, with a discount and a one-time allowance for materials.
2. Signature-VSP's premium plan that is full service (provides exam, lens, and frame) and utilizes VSP's most extensive provider network.
3. Medicaid with PEC-The benefit includes the State Medicaid plan along with VSP's Primary Eyecare benefit. The Primary EyeCare plan provides supplemental coverage for non-surgical medical eyecare through the VSP doctor.
4. Medicaid with PEC and GAP-The benefit includes the State Medicaid plan. The benefit is also available through a Group Authorized Provider (GAP). The Primary EyeCare plan provides supplemental coverage for non-surgical medical eyecare through the VSP doctor.
5. Straight Access-The Access Plan is a benefit option designed to accommodate clients that wish to provide members with discounts on basic services and materials.
6. Exam +-The Exam Plus Plan includes a comprehensive exam covered in full and discounts on materials and contact lens exam professional fees.

EXHIBIT C
DELEGATED FUNCTIONS

A. DELEGATED CREDENTIALING.

As a condition of the Vision Services Agreement, VSP shall perform credentialing and recredentialing functions in accordance with this Exhibit for all VSP Network Providers. VSP desires to accept the delegation of certain credentialing and recredentialing services in accordance with the terms and conditions of this Agreement.

1. Delegation.

1.1. Scope. Health Plans hereby delegate to VSP the credentialing and recredentialing services set forth in Exhibit C. Such delegation shall be effective for VSP Network Providers who have executed or will execute a Participation Agreement with VSP, in accordance with the terms and conditions set forth in this Section A of this Exhibit.

Standards. VSP agrees that it shall perform the Credentialing Services in accordance with the applicable Health Plan Accreditation Standards (NCQA, URAC, etc.) and the state and federal regulatory guidelines and mandates. In addition, VSP agrees that it shall comply with Health Plans' quality improvement program including but not limited to HEDIS, CAHPS, and related quality studies and monitoring.

2. Records.

2.1. Maintenance. VSP agrees to prepare and maintain all appropriate records from time to time as shall be necessary and appropriate for Health Plans to monitor the provision of Credentialing Services under this Section A of this Exhibit. All such records shall be maintained in accordance with prudent record-keeping procedures and as required by the Standards.

2.2. Access. Upon written notice to VSP, or as required by state or federal law, VSP shall allow Health Plans, and/or the appropriate state and/or federal agencies to review VSP's financial, accounting and administrative books and records relating to the provision or performance of Credentialing Services by and through VSP. Such review shall take place at the site where VSP maintains such records during VSP's normal business hours unless otherwise permitted by law.

3. Reservation of Rights.

3.1. General Oversight. Health Plans shall retain the right to oversee VSP's performance of the Credentialing Services. Accordingly, VSP's credentialing and recredentialing process shall be subject at all times to review and approval by Health Plans. Specifically, Health Plans shall have the right to review all information retained by VSP regarding the Credentialing Services, in order to evaluate VSP's compliance with the Standards and the terms of this Section A of this Exhibit. VSP shall make this information available to Health Plans, in accordance with Section 2.2, for such oversight purposes.

3.2. Action by Health Plans. Health Plans reserve the right to approve, suspend, or terminate any VSP Network Provider credentialed or recredentialed by VSP. In addition, as set forth in Section 4.3.3, Health Plans may rescind the delegation of the Credentialing Services if, in Health Plans' opinion, VSP's performance of the Credentialing Services jeopardizes either the health or safety of Members or Health Plans' compliance with applicable statutory, regulatory or other certification requirements and VSP has failed to take prompt corrective action after receiving notice of such problem from Health Plans.

4. Term/Termination.

4.1. Term. VSP shall perform delegated Credentialing Services for Health Plans concurrent with the term of the Agreement.

This language shall apply to 4.2 and 4.3: In the event that Health Plan terminates VSP's performance of Delegated Credentialing Activities in accordance with the terms of Exhibit C, either party reserves the right to terminate the Agreement upon thirty (30) days advance notice.

4.2. Termination without Cause. Either party may terminate the delegation of Credentialing Services by providing ninety (90) days prior written notice of such termination to the other Party.

4.3. Termination with Cause. The delegation of Credentialing Services may be terminated by the non-defaulting Party for cause of the defaulting party upon the happening of any of the following events of default and upon compliance with the notice provisions set forth below or elsewhere in this Agreement:

4.3.1. Failure to Meet Obligations. If either Party defaults in the performance of any material duties or obligations of the Credentialing Services outlined herein, including the inability or refusal to provide Credentialing Services hereunder, and such default has not been cured within thirty (30) days of the non-defaulting Party's giving of written notice of such default, specifying the nature of the alleged default or breach, the nondefaulting Party may give notice of intent to terminate the delegated credentialing arrangement to the other Party, and such delegation shall terminate on the sixtieth (60th) day following the date of such notice of intent to terminate. Notwithstanding the foregoing, the Parties understand and agree that Health Plans may first notify VSP that it must develop and implement an action plan to correct any failure to perform the Credentialing Services in accordance with Section A of this Exhibit.

4.3.2. Loss of Licensure or Insurance/Felony Conviction. Either Party may terminate this delegated Credentialing Services outlined herein immediately upon the: (i) suspension, revocation or termination of the other Party's license, if applicable; (ii) the other Party's loss of professional liability insurance; or (iii) the felony conviction or plea of nolo contendere of the other Party or any officer, director of employee of the other Party.

4.3.3. Danger to Health or Safety of Covered Individuals/Compliance with Regulations. Health Plans may choose to terminate its delegation of credentialing services to VSP if, in Health Plans' opinion, VSP's performance of the Credentialing Services jeopardizes the health or safety of Members or Health Plans' compliance with applicable statutory, regulatory or other certification requirements. Such termination may only take place if Health Plans has provided written notification to VSP of such problems and VSP has failed to take prompt corrective action.

4.4. Termination of Services Agreement. Delegation of Credentialing Services to VSP by Health Plans shall terminate immediately upon the termination, for any reason, of the Vision Services Agreement.

B. CLAIMS PROCESSING

1. Delegation.

1.1 Scope. Health Plans delegate to VSP responsibility for processing Claims received from VSP Network Providers for services provided to Members under the Agreement. VSP shall act in accordance with the Ethics and Fairness in Carrier Business Practices Act in Virginia and/or the Fair Business Practices Act in West Virginia, as set forth in Exhibit E and Exhibit D, and other applicable state and federal law, and accreditation requirements.

1.2 Health Plan Approval. VSP's claims processing activities are subject to review and approval by Health Plans. A copy of VSP's detailed Claims Processing policies and procedures shall be made available to Health Plans upon request.

2. Claims Processing Program.

2.1 Policies and Procedures. VSP shall maintain a documented description of VSP's Claim Processing Program which, at a minimum, satisfies the standards and procedures required by applicable laws and regulations. All delegated claims processing activities shall be performed by VSP in strict compliance with VSP's written Claims Processing Program as approved by Health Plans.

2.2 Standards for Claims Processing. VSP represents and warrants that VSP's Claim Processing Program shall be administered in accordance with standards and procedures established in accordance with State and Federal law standards and shall include, but is not limited to, the following:

2.2.1 All claims shall be processed within the time period required by State and Federal Law for payment of claims, as set forth in Exhibits E and D.

2.2.2 VSP shall have an appropriate medical review process in place to review claims when necessary.

2.2.3 VSP shall notify Members of any wholly or partially denied claim(s), for which the Member will have financial liability, within the time periods identified above. Such notice shall state the portion of the claim that is contested, the specific reasons for contesting the claim, and

information on how the Member may appeal VSP's initial determination through Health Plans' appeal and grievance program.

2.2.4 VSP must participate, cooperate, and comply with Health Plans for accessing medical records and/or any other documentation used by VSP in making benefit determinations under this Agreement.

C. QUALITY IMPROVEMENT

1. **Delegation of QI Activities:** Health plans delegate to VSP the responsibilities of maintaining an annual QI program description, workplan with at least semiannual reporting of QI monitoring and collaborative QI activities (including but not limited to data necessary for HEDIS® reporting and other QI studies) required by Health Plans for compliance with accreditation standards and state and federal regulations.

EXHIBIT D

WEST VIRGINIA BUSINESS PRACTICES STANDARDS

This Exhibit D shall apply to all payments Carelink (for itself and on behalf of CHLIC or Payor) makes to VSP related to Covered Services rendered to Members by West Virginia-based VSP Network Providers, and to all payments VSP makes to West Virginia-based VSP Network Providers, for Covered Services rendered to Members. To the extent anything in this Exhibit D conflicts with other provisions in the Agreement, the requirements of this Exhibit D shall govern. VSP shall adhere to the standards set forth below and include the same language in its Participation Agreements.

1. As applicable, Carelink's payments or denials to VSP, and VSP's payments or denials on Carelink's behalf to VSP Network Providers, shall be made within forty (40) days of receipt of the Clean Claim if submitted manually, or thirty (30) days of receipt of a Clean Claim if submitted electronically, except under the following circumstances:

(a) Another party is responsible for the Claim;
(b) Health Plan or VSP is coordinating benefits with another party;
(c) VSP or VSP Network Provider has already been paid for the Claim;
(d) The Claim was submitted fraudulently; or
(e) The Claim included a material misrepresentation.

Failure to pay Clean Claims pursuant to this Exhibit shall result in the accrual of interest in accordance with the *Ethics and Fairness in Carrier Business Practices Act*, W.Va. Code Title 33, Article 44, Section 2 (§ 33-45-2). Interest shall be paid and accompanied by an explanation of the assessment on each claim of interest paid, without necessity of demand, at the time the Claim is paid, or within thirty (30) days thereafter.

2. VSP shall submit Claims for reimbursement, as required by this Exhibit and the Agreement. VSP shall require VSP Network Providers to submit claims in accordance with Participation Agreements.

3. Carelink shall maintain a written or electronic record of the date a Claim was received from VSP. Likewise, VSP on Carelink's behalf shall maintain a written or electronic record of the date a Claim was received from VSP or a VSP Network Provider. VSP or VSP Network Provider, or other person submitting Claim on VSP's or VSP Network Provider's behalf, shall be entitled to inspect and rely upon such record, or any

other admissible evidence as proof of Carelink's or VSP's receipt of the Claim, including without limitation, electronic or facsimile copies. If Carelink, or VSP, fails to maintain electronic or written record of the date a Claim is received, the Claim shall be considered to have been received three (3) business days after the Claim was submitted, based on the written or electronic record of the date of submission by VSP or the VSP Network Provider, or person submitting the Claim on VSP's or VSP Network Provider's behalf.

4. Carelink shall not be responsible for paying VSP for a Claim (Clean or otherwise) for previously authorized Covered Services, and VSP shall not be responsible for paying a VSP Network Provider for a Claim (Clean or otherwise) for previously authorized Covered Services under any of the circumstances listed in Section 1 of this Exhibit D above, or as follows:

(a) The documentation for the Claim fails to support the Claim as originally authorized.
(b) The authorization was based in whole or material part on erroneous information provided to Carelink by VSP or a Member, or to VSP by VSP Network Provider or a Member.
(c) The person receiving the services was ineligible to receive the services, or the services were not Covered Services, and neither Carelink nor VSP nor VSP Network Provider knew, and could not have reasonably known about the ineligibility.
(d) The Claims are in dispute.
(e) The service provided was not a Covered Service and neither VSP nor Health Plans knew, or with the exercise of reasonable care could have known, at the time of the authorization, that the service was not a Covered Service.

5. Carelink or VSP on Carelink's behalf may require appropriate documentation and coding to support payment for Covered Services or determine whether a Claim is a Clean Claim. Carelink or VSP within thirty (30) days of receiving a Claim, may request electronically, or in writing, information and documentation, if any, that Carelink, or VSP, reasonably believes will be required in order to process and pay the Claim or to determine if the Claim is a Clean Claim. Carelink or VSP shall use all reasonable efforts to ask for all desired information in one request, and shall, if necessary, within fifteen (15) days of receipt of the information, (a) only request or require additional information one more time, if such additional information could not have been reasonably identified at the time of the original request or (b) specifically identify a material failure to provide the information requested in the initial request. Upon receipt of information under this Section, Carelink or VSP shall either make or deny payment within thirty (30) days.

6. Neither Carelink nor VSP acting on Carelink's behalf may refuse to pay a Clean Claim for Covered Services rendered pursuant to this Agreement, rendered by a VSP Network Provider pursuant to such VSP Network Provider's agreement with VSP if Carelink or VSP fails to timely notify, or attempt to timely notify, VSP or VSP Network Provider of the information needed, in accordance with Section 5 above, within thirty (30) days, unless such failure was caused in material part by the VSP, VSP Network

Provider, or person submitting the Claim on VSP or VSP Network Provider's behalf. Nothing herein, however, shall preclude Carelink or VSP from imposing a retroactive denial of payment of such claim as permitted by this Agreement or the Participation Agreement. For purposes of this Exhibit, "retroactive denial" means the practice of denying previously paid claims by withholding or setting off against payments, or in any other manner reducing or affecting the future claim payments to the provider, or to seek direct cash reimbursement from a provider for a payment previously made to the provider.

7. Carelink or VSP may reduce or deny payment for services which are not submitted for payment in accordance with the provisions of this Exhibit or the Agreement, or pertinent provisions of the Participation Agreement, or which are not billed or coded in accordance with generally accepted industry standards for billing and coding practices, which may include the use of industry accepted software to edit Claims to ensure appropriate billing and coding practices.

8. Neither Carelink nor VSP on Carelink's behalf may impose any retroactive denial of a previously paid claim unless (i) the original Claim was submitted fraudulently or contained material misrepresentations, (ii) the original Claim payment was incorrect because VSP or the VSP Network Provider was already paid for the Covered Services identified on the Claim or the Covered Services on the Claim were not delivered, (iii) VSP or the VSP Network Provider were not entitled to reimbursement; (iv) the service provided was not covered by Carelink or VSP; or (v) the Member was not eligible for reimbursement.

9. Within forty (40) days of receipt of a notice of retroactive denial, VSP shall notify Carelink, or VSP Network Providers shall notify VSP of its intent to pay or demand written explanation of the reasons for the retroactive denial. Upon receipt of explanation for retroactive denial, VSP shall reimburse Carelink, or VSP Network Provider shall reimburse VSP, within thirty (30) days for allowing an offset against future payments or provide written notice of dispute. Disputes shall be resolved between the parties within thirty (30) days of receipt of notice of dispute. Upon resolution of dispute pursuant to the process set forth in the Provider Manual, VSP or the VSP Network Provider shall pay any amount due or provide written authorization for an offset against future payments.

10. Carelink or VSP shall have one (1) year from the date the Claim was originally paid to make a retroactive denial when such denial is being made due to (ii), (iii), (iv) and (v) in Section 8 of this Exhibit D There shall be no time limitations for retroactive denials for Claims that were submitted fraudulently or that contained material misrepresentations

11. Carelink or VSP on Carelink's behalf shall establish and implement reasonable policies to permit VSP or any VSP Network Provider (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the service to be provided is a Covered Service and (ii) to determine requirements applicable to VSP or VSP Network Providers for (a) precertification or authorization of coverage

decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of Claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the Participation Agreement, including determining whether a Claim is a Clean Claim. In the event Carelink's provision of a policy to VSP or VSP Network Providers, or in the event VSP's provision of a policy to VSP Network Providers, regarding the applicable fee schedule, reimbursement policy or statement as to the manner in which Claims will be calculated and paid, or to the range of health care services reasonably expected to be delivered on a routine basis, would violate any applicable copyright law, Carelink may instead provide to VSP, and/or VSP may instead provide to VSP Network Providers, a clear, written explanation of the policy as it applies.

12. VSP agrees, and VSP shall require VSP Network Providers to agree in writing, that in no event, including, but not limited to, nonpayment by Health Plans or VSP, Health Plans or VSP insolvency, or breach of the Agreement or a Participation Agreement, shall VSP or VSP Network Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons other than Health Plans or VSP for services rendered under the Agreement. For purposes of this section, services rendered under the Agreement include those health care services delivered to Members by any and all health care professionals employed by or independently contracted with VSP and VSP Network Providers. This section shall not prohibit collection of copayments, coinsurance, or deductibles in accordance with the applicable Member Contract. VSP further agrees, and shall require VSP Network Providers to agree, that: (i) this provision shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between VSP, VSP Network Provider, a Member, or a person acting on Member's behalf. VSP shall include a section substantially similar to this Section in its Participation Agreements.

EXHIBIT E

VIRGINIA BUSINESS PRACTICES STANDARDS

This Exhibit E shall apply to all payment Southern Health makes to VSP (for itself and on behalf of CHLIC and Payors), and to all payments VSP makes to VSP Network Providers for Covered Services rendered to Members enrolled in groups sitused in Virginia. To the extent anything in this Exhibit E conflicts with other provisions in this Agreement, the requirements of this Exhibit E shall govern. VSP shall adhere to the standards set forth below and include the same language in its Participation Agreements.

I. PAYMENT OF CLEAN CLAIMS

1.1 Southern Health and Payors (collectively hereinafter referred to as "Southern Health") shall make payments to VSP, and VSP shall make payments to its VSP Network Providers, within forty (40) days of receipt of the claim, except where the obligation to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. the claim is determined not to be a Clean Claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. the claim was submitted fraudulently.

1.2 Southern Health and VSP on Southern Health's behalf shall maintain a written or electronic record of the date or receipt of claims received. The person submitting the claim shall be entitled to inspect such record or request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation, electronic or facsimiles confirmation of receipt of a claim. A claim must be filed with Southern Health or VSP within twelve (12) months of the date of service.

II. REQUEST FOR INFORMATION AND DOCUMENTATION

2.1 Southern Health or VSP on Southern Health's behalf shall, within thirty (30) days after receipt of a claim, request electronically or in writing from the person who submitted the claim the information and documentation, if

any, that Southern Health or VSP on Southern Health's behalf reasonably believes will be required in order to process and pay the claim or to determine if the claim is a Clean Claim. Upon receipt of the additional information requested necessary to make the original claim a Clean Claim, Southern Health or VSP shall make the payment of the claim in compliance with Virginia law and Section 1 above.

2.2 Southern Health shall not refuse to pay a claim for Covered Services rendered pursuant to this Agreement which are covered benefits if Southern Health or VSP fails to timely notify or attempt to notify the person who submitted the claim of the matters identified above unless such failure was caused in material part by the person who submitted the claims; however, nothing herein shall preclude Southern Health or VSP from paying a claim which is not a Clean Claim.

III. INTEREST

3.1 Southern Health or VSP on Southern Health's behalf shall pay any interest owing or accruing on a claim that requires interest payment to be made under Virginia law, without necessity of demand, at the time the claim is paid or within sixty (60) days thereafter, excluding time for mailing.

IV. VSP NETWORK PROVIDER REQUESTS FOR INFORMATION

4.1 Southern Health or VSP on Southern Health's behalf shall establish and implement reasonable policies to permit VSP or any VSP Network Provider (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the service to be provided is a Covered Service and (ii) to determine Southern Health's or VSP's applicable requirements for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of this Agreement, including determining whether a claim is a Clean Claim.

4.2 If Southern Health or VSP on Southern Health's behalf routinely, as a matter of policy, bundles or downcodes claims, Southern Health or VSP on Southern Health's behalf shall clearly disclose that practice, and the specific bundling and downcoding polices to be used in this Agreement, VSP Network Provider Agreements, or on their websites. If Southern Health or VSP on Southern Health's behalf routinely, as a matter of policy, bundles or downcodes claims, Southern Health or VSP on

Southern Health's behalf shall clearly disclose that practice and the specific bundling and downcoding polices to be used in this Agreement, VSP Network Provider Agreements, or on their websites

4.2.1 Further, Southern Health an VSP on Southern Health's behalf shall either

(i) disclose in this Agreement, VSP Network Provider Agreement, or on their websites, the specific bundling and downcoding policies that Southern Health, or VSP on behalf of Southern Health or Payor reasonably expects to be applied to VSP or a provider or VSP's or provider's services on a routine basis as a matter of policy or

(ii) disclose in this Agreement, and VSP, on behalf of Southern Health or Payor, shall disclose in each VSP Network Provider Agreement, a telephone or facsimile number or e-mail address that VSP or a VSP Network Provider can use to request the specific bundling and downcoding policies that Southern Health or VSP, on behalf of Southern Health or Payor, reasonably expects to be applied on a routine basis as a matter of policy. If such request is made by or on behalf of VSP or a VSP Network Provider, Southern Health or VSP on behalf of Southern Health or Payor shall provide VSP or the requesting VSP Network Provider with such policies within ten (10) working days following the date the request is received

4.3 Southern Health, or VSP on behalf of Southern Health or Payor, shall make available to VSP or a VSP Network Provider within ten (10) working days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to VSP, the VSP Network Provider, or to the particular Covered Services identified by VSP or the VSP Network Provider. In the event the provision of the entire policy would violate any applicable copyright law, Southern Health, or VSP on behalf of Southern Health or Payor, may instead comply with this requirement by timely delivering to VSP or a VSP Network Provider, a clear explanation of the policy as it applies to VSP or VSP Network Provider, and to any Covered Services identified by VSP or the VSP Network Provider.

V. AUTHORIZATION OF SERVICES

1. Southern Health, or VSP on behalf of Southern Health or Payor, shall pay a claim if Southern Health, or VSP on behalf of Southern Health or Payor, previously authorized the Covered Services or advised VSP, VSP Network Provider, or Enrollee, in advance of the provision of Covered Services that the services requested are Covered Services, unless

(i) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

(ii) Southern Health's refusal, or VSP's refusal on behalf of Southern Health or Payor, is because (i) another payor is responsible for payment, (ii) VSP or VSP Network Provider has already been paid for the Covered Services identified on the claim, (iii) the claim was submitted fraudulently or authorization was based in whole or material part on erroneous information provided to Southern Health or VSP, on behalf of Southern Health or Payor, by VSP, Enrollee, or other person not related to Southern Health or VSP, or (iv) the person receiving the Covered Services was not eligible to receive them on the date of service and Southern Health, or VSP on behalf of Southern Health or Payor, did not know, and with the exercise of reasonable care could not have know, of the person's eligibility status.

VI. RETROACTIVE DENIAL OF CLAIMS

1. For purposes of this Exhibit, the term "Retroactive Denial of a Previously Paid Claim" or "Retroactive Denial of Payment" means any attempt by Southern Health or VSP on Southern Health's behalf to retroactively collect payments already made to VSP or VSP Network Provider, or any attempt by VSP or VSP Network Provider to retroactively collect payments already made to VSP or a VSP Network Provider, with respect to a claim by reducing other payments currently owed, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claims payment to VSP, or payment to VSP Network Provider by VSP.

2. Southern Health, or VSP on behalf of Southern Health or Payor, shall not impose any Retroactive Denial of a Previously Paid Claim or Retroactive Denial of Payment, unless Southern Health, or VSP on behalf of Southern Health or Payor, provides the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because VSP or VSP Network Provider was already paid for the Covered Services identified on the claim or the Covered Services on the claim were not delivered by VSP or VSP Network Provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) twelve (12) months or (b) the number of days within which Southern Health, or VSP on behalf of Southern Health or Payor, requires under this Agreement that a claim be submitted by the provider following the date on which a health care

service is provided. Southern Health, or VSP on behalf of Southern Health or Payor, agrees to notify VSP or VSP Network Provider at least thirty (30) days in advance of any retroactive denial.

3. Southern Health, or VSP on behalf of Southern Health or Payor, shall not impose any retroactive denials of payment or in any other way seek recover or refund from a previously paid claims unless Southern Health, or VSP on behalf of Southern Health or Payor, specifies in writing the specific claim or claims for which the retroactive denial is to be imposed, or the recovery or refund is sought. Such written communications shall also contain an explanation of why the claim is being retroactively adjusted.

VII. INCLUSIONS OR ATTACHMENTS

7.1 Southern Health, or VSP on behalf of Southern Health or Payor, warrants that at the time this Exhibit and Agreement are presented to VSP or at the time that VSP presents similar language to VSP Network Providers for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to VSP or the VSP Network Providers to the range of Covered Services reasonably expected to be delivered by VSP or VSP Network Providers on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in Section IV) applicable to VSP or to VSP Network Providers to the range of Covered Services reasonably expected to be delivered by VSP or VSP Network Providers under this Agreement or the VSP Network Provider Agreement will be included or attached as part of this Agreement or the VSP Network Provider Agreement.

VIII. COPYRIGHT

8.1 In the event that Southern Health's provision of a policy required to be provided by the terms of this Exhibit, or VSP's provision of a policy on behalf of Southern Health or Payor, would violate any applicable copyright law, Southern Health, or VSP on behalf of Southern Health or Payor, may instead comply with this section by providing a clear, written explanation of the policy as it applies to VSP or VSP Network Provider.

IX. CLAIMS PAYMENT DISPUTES

9.1 Southern Health, or VSP on behalf of Southern Health or Payor, shall establish, in writing, Southern Health's, or VSP's on behalf of Southern Health or Payor, claims payment dispute mechanism and shall make this information available to VSP or VSP Network Providers.

X. HOLD HARMLESS

10.1 Neither VSP nor VSP Network Providers shall maintain any action at law against a Member to collect sums owed by Southern Health or a Payor. In the event Southern Health, a Payor, or VSP fails to pay for Covered Services as set forth herein, Member shall not be liable to VSP or VSP Network Provider for any sums owed by either VSP or Southern Health or Payor.

10.2 VSP hereby agrees, and shall require VSP Network Providers to agree in writing, that in no event, including but not limited to nonpayment by Southern Health, VSP, or a Payor, the insolvency of Southern Health, VSP, or a Payor, or breach of the Agreement, shall VSP or VSP Network Providers bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or persons other than Southern Health for Covered Services rendered under the Agreement. This Section 10 shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of the applicable Health Benefit Plan.

10.3 VSP agrees, and shall require VSP Network Providers to agree in writing, that the requirements set forth in this Section 10 (i) shall survive the termination of the Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Members, and (ii) supersede any oral or written agreement to the contrary now or hereafter entered into between VSP or VSP Network Providers and the Members or persons acting on a Member's behalf.

Exhibit F

VIRGINIA MEDICAID (CARENET) AND WEST VIRGINIA MEDICAID PRODUCT GUIDELINES

1. No terms of this Amendment are valid which terminate legal liability of Health Plans in their Medicaid HMO Contracts.
2. VSP agrees, and shall require VSP Network Providers to agree, to participate in and contribute required data to Health Plans' quality improvement and other assurance programs as required by the West Virginia and Virginia Medicaid programs.
3. VSP agrees, and shall require VSP Network Providers to agree, to abide by the terms of the West Virginia and Virginia Medicaid programs for the timely provision of emergency and urgent care. Where applicable, VSP agrees, and shall require VSP Network Providers to agree, to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by Health Plans in accordance with the West Virginia and Virginia Medicaid programs.
4. VSP agrees, and shall require VSP Network Providers to agree, to submit utilization/encounter data in the format specified by Health Plans, so Health Plans can meet applicable agency specifications.
5. VSP agrees, and shall require VSP Network Providers to agree, to comply with all non-discrimination requirements in the West Virginia and Virginia Medicaid programs.
6. VSP agrees, and shall require VSP Network Providers to agree, to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilization and hysterectomies stipulated in the West Virginia and Virginia Medicaid programs.
7. VSP agrees, and shall require VSP Network Providers to agree, to provide representatives of Health Plans, as well as duly authorized agents or representatives of the Agency, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Units access to its premises and its contract and/or medical records in accordance with the West Virginia and Virginia Medicaid programs. VSP agrees, and shall require VSP Network Providers to agree, to otherwise to preserve the full confidentiality of medical records in accordance with the West Virginia and Virginia Medicaid programs.
8. VSP agrees, and shall require VSP Network Providers to agree, to the requirements for maintenance and transfer of medical records stipulated in the West Virginia and Virginia Medicaid programs. VSP agrees, and shall require VSP Network Providers to agree, to make medical records available to recipients and their authorized representatives within ten (10) working days of the record request.
9. VSP agrees, and shall require VSP Network Providers to agree, to ensure confidentiality of family planning services in accordance with the West Virginia and Virginia Medicaid programs, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

10. VSP shall not, and shall prohibit VSP Network Providers from creating barriers to access to care by imposing requirements on recipients that are inconsistent with the provision of Medically Necessary and Covered Benefit Services under the Medicaid programs.
11. VSP agrees, and shall require VSP Network Providers to agree, to clearly specify referral approval requirements to his/her providers and in any sub-contracts.
12. VSP shall not bill, and shall prohibit VSP Network Providers from billing, a Health Plan Medicaid Member for Medically Necessary Medicaid Covered Benefit Services provided during the Health Plans' Medicaid Member's period of enrollment in the Health Plan. This provision shall continue to be in effect even if Health Plans become insolvent. However, if a Health Plan Medicaid Member agrees in writing in advance of receiving the service to pay for a non-Medicaid covered service, then VSP/VSP Network Provider, Health Plans, or a subcontractor of Health Plans may bill the Medicaid Member.
13. VSP agrees, and shall require VSP Network Providers to agree, to forward to Health Plans medical records, within ten (10) working days of Health Plans' request.
14. VSP agrees, and shall require VSP Network Providers to agree, to promptly provide or arrange for the provision of all services required under the Participation Agreement and this Agreement.
15. Health Plans shall pay VSP, and VSP shall pay VSP Network Providers within thirty (30) days of the receipt of a Clean Claim for Medicaid Covered Services rendered to Health Plans' Medicaid Members unless another timeframe in which payment must be made is mutually agreed upon by the parties.
16. Notwithstanding any other provision to the contrary, the obligations of Health Plans hereunder shall be limited to annual appropriations by the governing bodies in the Commonwealth of Virginia and the State of West Virginia with respect to the states' Medicaid programs.

Exhibit G

MEDICARE PRODUCT GUIDELINES

The following provisions are required by the Medicare Advantage ("MA") Program and shall only apply to Covered Services rendered to Health Plans' Members enrolled in one of Health Plans' Medicare products. In the event of changes to the governing laws, regulations, or agency requirements applicable to the MA Program, this Exhibit G shall be superseded to the extent required by any such later required changes. In the event of any inconsistency between the Agreement and this Exhibit G, as pertains to Health Plans' MA Members or activities, the terms of this Exhibit G shall govern. VSP shall, and shall require VSP Network Providers to, comply with these terms and conditions with respect to rendering Covered Services to Health Plans' MA members.

1. **Audit and Inspection**.

   a. The Department of Health and Human Services ("HHS"), the Comptroller General, or their designees shall have the right to audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of VSP and/or VSP Network Providers that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the Agreement, including this Exhibit, or as the Secretary of HHS may deem necessary to enforce the Agreement and/or this Schedule.

   b. VSP agrees to make available, and shall require VSP Network Providers to agree to make available, for the purposes of protecting beneficiaries, and protecting against fraud, its premises, physical facilities, and equipment, records relating to MA Members, and any additional relevant information that the Centers for Medicare and Medicaid Services ("CMS") may require.

   c. HHS, the Comptroller General, or their designees, have the right to inspect, evaluate, and audit for a period of ten (10) years from the end of the termination of the Agreement, or completion of an audit, whichever is later, unless such time frame is extended pursuant to 42 C.F.R. § 422.502(e)(4) (such as in the event of fraud). This provision shall survive termination of the Agreement.

2. **Maintenance and Audit of Records**. VSP shall preserve, and shall require VSP Network Providers to preserve, records for the longer of (a) ten (10) years from the date the Agreement ends, or from the date of completion of any audit, whichever is longer, or longer if so required by CMS or (b) as required by state law.

3. **Requirements Binding Upon VSP Network Providers**. VSP's Participation Agreements with VSP Network Providers shall be in writing and shall specify the delegated activities and reporting responsibilities. VSP shall include in such Participation Agreements all of the contractual and legal obligations required by Health Plans, or the

laws, regulations, rules and directions of CMS including, but not limited to, those described in this Exhibit G, and 42 CFR 422.504(i)(4), and any other applicable state and/or federal law. To the extent CMS requires additional provisions to be included in such Participation Agreements, VSP shall amend its contracts accordingly. Health Plans reserve the right to revoke, or otherwise limit, VSP's ability to use subcontractors at any time.

4. **Prompt Payment.** Health Plans shall pay all Clean Claims, as that term is defined in the Agreement and applicable state law. Any interest payment requirements that may be due pursuant to the Agreement are not applicable to payments made by Health Plans for services rendered to MA Members.

5. **Compliance With Laws.** VSP shall require all VSP Network Providers to comply with all applicable Medicare laws, regulations and CMS instructions. Any provision required to be in the Agreement by the rules and regulations governing the MA Program shall bind the parties whether or not provided in the Agreement. In addition, to the extent applicable, VSP shall comply with the obligations in the contract between CMS and Health Plans governing Health Plans' participation in the MA Program, and VSP shall require same from VSP Network Providers.

6. **Accountability and Delegation.** To the extent that VSP has been delegated any activities or functions which are the responsibility of Health Plans, VSP shall make such periodic and other reports as reasonably required by Health Plans, and Health Plans shall at all times retain the right to monitor VSP's performance thereof through its quality assurance and improvement or other programs. Health Plans reserves the right to revoke such delegation in the event that either Health Plans or CMS determines that such activities or functions have not been performed in a satisfactory manner.

7. **Credentialing.** If Health Plans delegates credentialing or recredentialing to VSP, VSP's credentialing/recredentialing process is subject to review and approval by Health Plans. Health Plans shall also be entitled to audit such credentialing/recredentialing process on an ongoing basis. If Health Plans delegate selection of providers, contractors, or subcontractors to VSP, Health Plans retain the right to approve, suspend, or terminate any such arrangement at any time, in its own discretion. Health Plans reserves the right to review the credentials of any health care professional credentialed/recredentialed by VSP. Health Plans reserve the right to revoke, or otherwise limit, any delegated credentialing functions that VSP performs, as stated in Section 6 above.

8. **Provider Manual/Participation Procedures.** The Provider Manual sets forth Health Plans' administrative procedures for operationalizing many of the requirements of the Agreement and the MA Program. Health Plans may modify the Provider Manual from time to time. VSP shall comply with the requirements set forth in the Provider Manual, and shall require VSP Network Providers to comply with the requirements set forth in the Provider Manual, as applicable. In the event of any inconsistency between the Provider Manual and this Exhibit, the terms of this Exhibit shall govern.

9. **Receipt of Federal Funds**. VSP understands and agrees, and shall require VSP Network Providers to understand and agree, that payments received by Health Plans from CMS pursuant to Health Plans' contract with CMS are Federal funds. As a result, VSP, by entering into the Agreement and this Exhibit, and VSP Network Providers by entering into the Participation Agreements, are 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.

10. **Submission and Certification of Data**

    a. VSP hereby acknowledges that Health Plans are 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 VSP or VSP Network Provider and a Health Plan MA Member. VSP agrees to cooperate, and shall require VSP Network Providers to agree to cooperate, with Health Plans and provide Health Plans with all such information in such form and manner as requested by Health Plans.

    b. VSP recognizes that as a MA organization, Health Plans are 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 Health Plans by its contractors and subcontractors. VSP and VSP Network Providers hereby certify that any such data submitted to Health Plans will be accurate, complete and truthful. Upon request, VSP and VSP Network Providers shall make such certification in the form and manner prescribed by Health Plans.

11. **Relationships with Excluded Entities**. VSP shall not employ or contract, and VSP shall prohibit VSP Network Providers from employing or contracting, for the provision of health care, utilization review, medical social work or administrative services with any individual excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. VSP hereby certifies, and VSP shall require VSP Network Providers to certify, that no such excluded person currently is employed by or under contract with VSP or VSP Network Providers, or with any "downstream" entity with which VSP or VSP Network Providers contract relating to the furnishing of these services to Medicare Members. VSP shall review, and VSP shall require VSP Network Providers to review, the Department of Health and Human Services Office of the Inspector General (OIG) and the General Services Administration (GSA) exclusion lists for all new employees, independent contractors and downstream entities with which VSP and VSP Network Providers contracts and, at least annually, to confirm that current employees, independent contractors and downstream entities have not been excluded, sanctioned, or otherwise barred from participating in the Medicare/Medicaid programs.

12. **Compensation.** Health Plans shall pay VSP in accordance with Exhibit A to the Agreement.

The following Sections 13, 14, and 15 shall apply only to those VSP Network Providers that dispense outpatient prescription drugs that are covered under Medicare Part D (such as, but not limited to, home infusion drugs).

13. **Price Differential.** VSP shall require that, at the time of purchase by a MA Member, VSP Network Providers must inform the MA Member of any differential between the price of the Home Infusion Pharmaceutical Product being dispensed and the price of the lowest priced generic version of that Home Infusion Pharmaceutical Product available from VSP Network Provider, unless the Home Infusion Pharmaceutical Product being dispensed is the lowest priced generic version of that Home Infusion Pharmaceutical Product.

14. **MA Member Counseling and Enrollee Information.** VSP shall require that VSP Network Providers offer counseling to MA Members, when appropriate. Furthermore, VSP shall require that VSP Network Providers implement a method for maintaining up-to-date MA Member information, including, but not limited to, Member demographic information and food and drug allergy information.

15. **Submission of Claims.** If VSP Network Provider submits a hard-copy or tape claim to VSP, and VSP rejects such hard-copy or tape claim due to an error by VSP Network Provider, VSP Network Provider shall have sixty (60) days from the date the Covered Service was provided to MA Member to resubmit such claim without error, or such other time period as determined by VSP, and as set forth in the applicable Provider Manual. If VSP submits a hard-copy or tape claim to Health Plans, and Health Plans reject such hard-copy or tape claim due to an error by VSP, VSP shall have sixty (60) days from the date the Covered Service was provided to MA Member to resubmit such claim without error, or such other time period as determined by Health Plans, and as set forth in the applicable Provider Manual.

PERFORMANCE GUARANTEES
EXHIBIT H

Performance Activity	SHS Performance Standard	Performance Penalty
I. CLAIMS STANDARDS		
▪ Claims processing	▪ 85% clean claims within 15 cal days	▪ $2,500 quarterly
▪ Financial Accuracy	▪ ≥ 99% this is planwide measurement for PGs	▪ $2,500 quarterly
▪ Claims Payment Accuracy	▪ 98% planwide	▪ $2,500 quarterly
II. Customer Care Standards		
a. Commercial Virginia, West Virginia and West Virginia Medicaid		
▪ Intake Avg Speed of Answer	▪ 30 Seconds	▪ $2,500 quarterly
▪ Call Abandonment	▪ ≤ 5%	▪ $2,500 quarterly
b. CareNet (Virginia Medicaid)		
▪ Intake Avg Speed of Answer	▪ 20 Seconds	▪ $2,500 quarterly
▪ Call Abandonment	▪ ≤ 5%	▪ $2,500 quarterly

CLINICAL REPORTING
EXHIBIT I

Report Name	Report Description	Frequency
Network Provider Listing	Excel format Commercial and Medicaid	Monthly by the 5th of the month
Client Utilization Report	Claims utilization	Monthly
Call Response Summary Report	Call Response	Monthly
Encounter Data	Claims and provider data transfer	Monthly by the 10th of the month
HEDIS Reporting		Yearly or upon request
Performance Guarantee Reporting	Performance guarantees of claims processing, accuracy and customer services for the previous months.	Quarterly

Cotiviti Subcontractor Agreement

SCHEDULE NO. 12
TO THE
PROFESSIONAL SERVICES AGREEMENT
BETWEEN
AETNA LIFE INSURANCE COMPANY
AND
COTIVITI, LLC.

The Parties agree that the terms and conditions of the Professional Services Agreement dated July 10th, 2000 (the "Agreement") between Aetna Life Insurance Company (hereinafter "Aetna" or "Client") and Cotiviti, LLC ("Cotiviti" or "Supplier") shall govern this Schedule No. 12 (the "Schedule"). In the event of a conflict between the terms and conditions of this Schedule and the terms and conditions of the Agreement, this Schedule shall prevail.

1. EFFECTIVE DATE: July1, 2017

2. AETNA/SUPPLIER KEY PERSONNEL:

A. Aetna Project Manager: Amanda Purvis
B. Supplier Project Lead: Kevin McDonald
C. Aetna Procurement Lead: Sowji Atluri

3. SERVICES:

Supplier will perform data mining and recovery audit services for Client for purposes of identifying and recovering overpaid and/or improperly paid medical claims payments (and other claim recovery opportunities), as further described in Exhibit A, Statement of Work (the "Services"). The Services rendered pursuant to this Schedule 12 will be made available only to those Aetna Medicaid lines of business specified in Exhibit C to this Schedule, irrespective of whether the names of such lines of business change names, merge, or undergo other corporate structure changes.

This assignment cannot be altered without the consent of both Aetna and Supplier. Supplier shall provide any supervision of a Supplier employee's day-to-day services.

Renewals and subsequent acquisitions of additional goods or Services described under this Schedule may be acquired via mutually executed amendment to this Schedule. In the event that the Services performed under this Schedule continue beyond the term set forth in Section 6, Term/Payment Schedule/Fees, below, the parties agree that this Schedule shall survive until an amendment for such extension is executed.

(For Administrative Purposes only) UNSPSC: 84131608

4. ASSIGNMENT LOCATION(S):

A. Services will be performed by Supplier at various Cotiviti U.S. based offices.
B. Supplier shall not perform, or engage or pay any individual or entity, to perform any services for Client under this Schedule 12 if Supplier, or 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). The Parties agree that no Aetna Medicaid data, records, or Personal Health Information (PHI), in any form (electronic or otherwise), shall be sent, accessed or stored offshore.

5. SUPPLIER EMPLOYEE(S):

A. H-1B Visa: If Supplier intends on utilizing H-1B employees in the performance of this Schedule the Supplier must comply with all applicable laws and regulations regarding the utilization of such H-1B employees.

6. TERM/PAYMENT SCHEDULE/FEES:

The Schedule shall commence as of the Effective Date, and, unless terminated earlier as permitted in this Schedule or pursuant to the terms of the Agreement, shall continue through June 30, 2020 (the "Term"). After the Term, this Schedule shall automatically renew on an annual basis for up to three (3) successive periods of one (1) year each (each a "Renewal Term") unless either party gives the other party written notice of non-renewal at least sixty (60) days prior to the end of the Initial Term or the then-current Renewal Term.

The payment schedule and Fees are set forth in Section 13 of Exhibit A, *Statement of Work*. However, the fees set forth in Exhibit A are subject to adjustment in the event of a Material Change in Membership. For purposes of this Schedule, a "Material Change in Membership" is defined as an aggregate net increase or decrease of 30% or more in the total membership of those Health Plans specified in Exhibit C, as compared to such total membership from the immediately preceding annual contract period. Provided, that, should any Health Plan in Exhibit C be dissolved, sold or otherwise ceases to exist as an Aetna Affiliate, such Health Plan's membership will no longer be considered a part of the total membership under Exhibit C when determining whether a Material Change in Membership has occurred.

In the event a Material Change in Membership has occurred, either party may provide the other party with written notice, thereby triggering a good-faith, renegotiation of fees set forth in Section 13 in order to adjust such fees commensurately in contemplation of the present circumstances. All resultant changes to the fee structure shall be codified in a mutually executed amendment to this Schedule. Provided, however, that Material Change in Membership shall not be deemed to have occurred unless such increase or decrease in membership translates directly to a net 30% increase or decrease of in-scope Services under this Schedule..

Upon termination of this Schedule, Supplier shall provide to Aetna all Materials produced as part of the Services.

7. SALES & USE TAXES: Aetna will receive the benefit of the Services in Connecticut.

8. INVOICE QUESTIONS: Any questions regarding invoices submitted for payment must be directed to Aetna's Procurement Customer Care line at 888-238-6227 or email at APCustomerCare@Aetna.com.

9. RECORDS RETENTION:

Supplier will retain Aetna business records as required by applicable federal and state laws, including Medicaid and Medicare Advantage requirements, for all performance and financial records related to the contract for a period of 10 years from the date of the contract period to which the records relate or the date of completion of any government audit, whichever is later.

10. OTHER PROVISIONS.

Supplier shall adhere to the State-Specific Compliance Addenda attached hereto as Exhibit B and its sub-exhibits, and the Medicare Services terms set forth in the Agreement, as applicable to the Services. In the event that applicable law changes in any of the states in which Services are performed and such change in law results in a conflict with the terms of the State-Specific Compliance Addenda, the parties agree to comply with applicable law(s).

IN WITNESS WHEREOF, the Parties have hereto by their duly authorized representatives executed this Schedule.

AETNA LIFE INSURANCE COMPANY	**COTIVITI, LLC**
Marc Marini (Jul 24, 2017)	Jonathan Olefson (Jul 23, 2017)

Authorized Signature	Authorized Signature
Marc Marini	Jonathan Olefson
Print Name	Print Name
Marc Marini	General Counsel
Title	Title
Jul 24, 2017	Jul 23, 2017
Date	Date

STATEMENT OF WORK

Supplier Name/Project Name	Cotiviti/Recovery audit for the projects, claim concepts and claims system areas for Aetna Better Health Medicaid Plans
Governing Contract	Professional Services Agreement dated July 10, 2000
Procurement Lead	Sowjanya Atluri
Aetna Project Manager/Contact	Amanda Purvis
SOW Term Date	07/01/2017 – June 30, 2020
UNSPSC Code(For Aetna administrative use Only)	84131608

1. Description of Services and Deliverables:

1.1. Cotiviti will perform data mining and recovery audit services for Client's Health Plan Affiliates in order to identify and recover overpaid and improper medical claim payments (and other claim recovery opportunities set forth in Section 1.2 below), (the "Services"). In performance of the Services, Cotiviti will identify and validate overpayments that have not yet been identified and/or corrected (each, a "Cotiviti Opportunity"). For each Cotiviti Opportunity identified by Cotiviti, Cotiviti will be entitled to a percentage of the recovered claim opportunity as described in Section 13, for amounts actually recovered in connection with the Cotiviti Opportunity. Cotiviti will use reasonable efforts to perform the Service in a manner which minimizes disruptions to Client's daily processes.

1.2. Cotiviti will provide Client with recovery audits for the claim types set forth in Section 13, at the respective Pass Positions, Start Dates, and Rates set forth in Section 13. The Services include audits of areas such as data mining, contract compliance, provider billing errors, coordination of benefits ("COB") (including identifying Medicare and commercial primary payors or other liable payors), multiple payments, short stay, pharmacy (e.g., high cost drugs, units, cross platform drug audit, etc.), Diagnostic Related Grouper ("DRG") validation, , implant Audits/High Cost Drug ("HCD") invoice, specialty audits (Skilled Nursing Facility ("SNF")/Inpatient Rehab Facility ("IRF")/Durable Medical Equipment ("DME").

1.3. Cotiviti will provide support as requested by the Client for review and identification of overpayments based on files received by Aetna from the Center for Medicare and Medicaid Services ("CMS") on a quarterly basis for the purpose of coordination of benefits. Cotiviti's review shall follow Client's internal processes and rules and follow directions from the Client when volume creates a need for external support of internal process. Client reserves the right to request assistance with validation and/or collection of overpaid dollars based on review of other sources of COB Information as additional data sources become available.

1.4. The Services outlined herein shall be offered by Cotiviti to those Aetna Affiliate Aetna Better Health Plans set forth in Exhibit C to this Schedule (the "Health Plans"). Exhibit C may be modified by mutual agreement via amendment to this Schedule. On or after the Effective Date of this Schedule, each of the Health Plans will have the opportunity to opt into Services. Health Plans may decide, in their sole discretion, which service offerings/audit types to elect to receive. The Client Relationship Manager will partner with Cotiviti to develop an implementation plan consistent with the needs and deployment schedule elected by the Health Plan. Notwithstanding anything else in this Schedule and for the avoidance of doubt, Section 1.5 of the Agreement applies to the Services outlined herein.

1.5. Cotiviti will send recovery notification letters to providers with an explanation of the specific overpayment and the Client's collection process. Letters distributed by Cotiviti will comply with all applicable laws and regulations, and conform to guidelines set forth in the Agreement. Client's current preference is to process recovery claims as offsets to the providers' future remittances, when possible. However, when offsets are not allowed by provider contract or state regulations or when the Client is unable to offset, it is the expectation of the Client that the Supplier will seek recovery via a refund check to Client or other form of settlement acceptable to Client.

1.6. INTENTIONALLY OMITTED.

1.7. Cotiviti will provide a credit each monthly invoice in the amount equivalent to the cost of Aetna employing 3-4 full time employees who will process recoveries obtained by Cotiviti on behalf of Aetna in Aetna's QNXT platform, performing rework and refund posting activities associated with recoveries generated by Cotiviti. The Client will provide Cotiviti with an itemized accounting (on a quarterly basis) detailing the cost of the 3-4 full time employees contemplated above.

For avoidance of doubt, the Parties acknowledge and agree that any person hired by a party, including the resources contemplated to be hired by Client pursuant to this Section 1.7, will be an employee, agent or contractor of such party, and not an employee, agent or contractor of the other, and each party has the sole right and obligation to supervise, manage, compensate, collect and remit withholding and other employment taxes, contract, direct, procure or cause to be performed, all work to be performed by their respective employees. The employees of each party shall not be entitled to any benefits, coverages, or privileges, including, without limitation, social security, unemployment compensation insurance, workers' compensation insurance, medical benefits, or pension or other financial payments (including without limitation bonuses and 401K contributions) customarily made available to by the other party to it's employees.

1.8. Cotiviti and Client shall meet periodically to review the progress of the Services, discuss recent audit findings and trends, review any root cause analysis recently performed, methodologies for handling specific type of claims or issues, and recommendations to increase payment integrity opportunities. In the event Client imposes audit exclusions (for example, no audits for a given set of providers), the parties agree to meet annually to review Client's exclusion list for continuing applicability.

2. Supplier Concept Validation:

2.1. As part of the Services, Cotiviti will be required to participate and comply with Aetna's Better Health Plan Steering Committee Concept Adoption Program. Pursuant to the Concept Adoption Program, Aetna reserves the right to include additional overpayment services within the Concept Adoption Program. Cotiviti will be notified of additional overpayment services a minimum of 30 days in advance of concept submission.

2.2. Cotiviti will submit new policy related overpayment concepts for validation review by loading the claims into Cotiviti RCA SQUISH database prior to sending letters.

2.3. Each concept validation submission will be in an excel format posted to the designated SQUISH database. Aetna's Medicaid Steering Committee will vote on concepts for adoption for overpayment pursuit, evaluating validity and accuracy.

2.4. Client will review and approve (or deny) all new policy related overpayment concepts within ten (10) business days of receipt. Once the review of the entire file is complete, the Aetna Medicaid Steering Committee will approve (or deny) the concept with an email communication from the Cotiviti RCA SQUISH database. Provided, however, that concepts not expressly approved by Client shall be deemed to be denied unless otherwise mutually agreed to by the parties.

2.5 If Client declines valid concepts as not approved, it will be discussed during a weekly call with the Aetna Steering Committee and be closed out of the Cotiviti RCA SQUISH database.

Client may not disclose a Cotiviti - identified concept submission to a competitor of Supplier nor may Client pursue claims identified by Cotiviti as part of the concept validation process internally unless the internal concept is materially different. This provision should not be interpreted to prevent i) Client from instituting process improvements or system updates that prevent overpayments or ii) Client from approving a similar concept for another supplier.

3. **Quality**:

3.1 On a monthly basis, Cotiviti will maintain a 95% or greater quality score (the "Quality Score"). The Quality Score will be based on valid overpayments identified and attributable to Cotiviti. Aetna will distribute a quality report by the fifth business day of each month with the previous month's results. The Quality Score is obtained by the total of approved claims divided by the total of claims submitted by Cotiviti within that specified month. Claims denied due to no fault of Cotiviti will be removed from the numerator and denominator when calculating the Quality Score.

If Cotiviti fails to meet the quality score standard for two consecutive months, Supplier will develop a corrective action plan that will be mutually agreed upon by Aetna and Cotiviti. If Supplier fails to complete the corrective action plan, a performance credit equal to $1,000 per quarter will be assessed for each quarter that the corrective action plan remains incomplete, subject to Section 9.1 of this Schedule.

The criteria comprising the quality score standard of 95% shall be mutually agreed upon by Supplier and Aetna within thirty (30) days of the execution of this agreement, and shall be incorporated by reference into this Schedule once agreed upon.

4. **Adherence to Due Dates:**

4.1. Supplier and Aetna will abide by mutually-agreed to dates for operations and reporting results to be due. Missed deadlines will be addressed as a standing item on operations meetings.

5. **Returned Commissions:**

5.1. Where commissions have been overpaid to Supplier by Aetna and must be returned to Aetna, Cotiviti must refund such overpaid commission amounts within 60 calendar days from the date of notice from Aetna regarding such overpaid commission amounts. If Cotiviti fails repeatedly* to return overpaid commissions within sixty (60) calendar days from the date Aetna notified Supplier of the need to return, Cotiviti will be placed on a corrective action plan. If Cotiviti fails to complete the corrective action plan to Aetna's reasonable satisfaction, , a performance credit equal to $1000 per week will be assessed for each week that the corrective action plan remains incomplete, subject to Section 9.1 of this Schedule.

* For the purposes of this Section 5.1, ('repeatedly' shall be as determined by Aetna in its sole reasonable discretion, provided that in no event shall a 10% failure rate be deemed to not be within the definition of 'repeatedly'.

6. **Partial Recovery:**

6.1. Where Cotiviti has received a partial payment or recovered less than the actual overpayment amount from a provider, Cotiviti is to review and determine if the remaining balance is to be recovered. Where Cotiviti has recovered more than 70% of the overpayment amount from a particular provider, and determines that the remaining balance remains due, Cotiviti must provide support as to why the balance remains and is continuing to be pursued.

6.2. If upon review, the remaining balance is determined not to be valid or is uncollectable, the Cotiviti will close the overpayment and notify Aetna Better Health. All review and notifications regarding remaining balances should be completed by Cotiviti within five (5) days of receipt of partial payment.

7. **Speed to Recovery**

7.1. Contracted Services.

All Recoveries will be consistent with Plan requirements and mutually agreed upon policies and procedures.

8. Appeals and Reconsiderations:

8.1. Cotiviti will perform appeals and reconsiderations in accordance with Aetna Better Health's Dispute, Reconsiderations, Complaints, Grievances and Appeals policy specific to the Cotiviti engagement.

9. Performance Credit Cap:

9.1. In no event shall the cumulative performance credits assessed pursuant to this Schedule exceed $15,000 in the aggregate in any calendar quarter (the "Performance Credit Cap").

10. Client Duties and Obligations:

10.1. Client will provide Cotiviti, as soon as practical, with all reasonably necessary (a) information, (b) system access and (c) electronic data files to enable Cotiviti to perform the Services and develop data mining tools, procedures and diagnostics tools to perform and support the Services. This includes appropriate access to Client's QNXT claim system, copies of relevant provider contracts, relevant rate and fee schedules, eligibility and membership data, Client's claim payment policies and procedures and access to claim images to support the audit. Client will deliver such information and electronic data files to Cotiviti via secure file transport protocol (SFTP) or other encrypted method of data transfer. Cotiviti shall in all instances adhere to all Client claim policies and procedures and other standard operating procedures (SOPs) applicable to the Services.

10.2. Client will provide Cotiviti with sufficient access and/or data to assess the status of each claim's disposition with respect to overpayment activity and to distinguish Cotiviti Opportunities from instances in which Client (or another vendor) has already pursued an overpayment with respect to a claim. Client will provide Cotiviti with an electronic record of all overpayments (partial and full adjustments) processed each month.

10.3. Client will provide Cotiviti with reasonable cooperation in connection with the Services, including all reasonably requested information, documentation, files and prior audit results (as applicable).

11. Documentation and Reports:

11.1. Client and Cotiviti will establish a frequency and format for verbal and written claim reports that will be prepared by Cotiviti.

(a) Verbal Reporting: Verbal updates attempt to provide Client with timely updates of the Services, such as observations and trends that might benefit Client.

(b) Management Reporting: Written reports provide a more formal presentation of findings to date, recommendations and potential refinements of the audit scope. These reports may also include operational weaknesses identified by Cotiviti, with suggestions for preventative and compliance improvements. Management reports are generally issued once each calendar annual.

(c) Monthly Reports. Cotiviti will provide Client with a monthly status reports on the progress of the Services, the amount of potential claims written to date, the number of claims processed, etc.

12. Acceptance of Deliverables:

12.1 Acceptance of Services shall be at Aetna's sole reasonable discretion. Aetna shall provide Supplier with written notice of non-acceptance that sets forth, in reasonable detail, the reason(s) for non acceptance. Supplier will promptly re-perform any Services not meeting the acceptance criteria, at no additional cost to Aetna.

13. Fees and Payment Schedules:

13.1. In exchange for performance of the Services, Cotiviti shall receive a percentage (as set forth below) of (a) all net-recoveries collected by Client or Cotiviti as a result of the Cotiviti Opportunities as cash or deductions or offsets, and (b) any settlements or other offset amounts received by Client that arise from the Cotiviti Opportunities.

13.2. The rates are effective for the duration of the term of this Schedule unless otherwise modified as permitted herein.

13.3. Upon and after termination or expiration of this Schedule, Cotiviti will be entitled to recover payment for Services rendered, including all net-recoveries for services rendered that are contingent upon receipt of settlement or funds from a third-party and are received by Client within 12 months after termination or expiration of this Schedule.

13.4. Cotiviti shall invoice Aetna on a monthly basis (on the 15th of the month) as per the invoicing and payment terms set forth in the Agreement. If Cotiviti experiences unexpected delays in remitting the invoice to Aetna, Cotiviti must notify Aetna within 24 hours of expected delivery.

Table 1: Audit Type, Pass position, Start Date, and Rates

Audit Type	Pass Position	Start Date	Percentage of Recovery Rates
COB	2nd*	91-150	[redacted]
Contract Compliance	1st	91***	[redacted]
Cross Platform Drug Audit	1st	91***	[redacted]
Data Mining	1st	91***	[redacted]
DRG Audit	1st	0**	[redacted]
Duplicate Services	1st	91***	[redacted]
High Cost Drug (units)	1st	91***	[redacted]
Implant Audits/HCD Invoice	1st	91***	[redacted]
Short Stay	1st	0	[redacted]
Specialty Audit (SNF/IRF/DME)	1st	0	[redacted]

- The total value of orders against this Schedule shall not exceed [redacted].

** Should an additional supplier be implemented during the term of this Schedule, Client agrees to provide Cotiviti with a ninety (90)-day period to review paid claim data for DRG Audit , Short Stay, Specialty Audit (SNF/IRF/DME), S this Schedule prior to the additional supplier being allowed to identify overpayments in these audit types. The 90-day review period shall start with the first day following claim payment. .

*** Should an additional supplier be implemented during the term of this Schedule, Client agrees to provide Cotiviti with an additional ninety (90)-day period from the Start Date as mentioned in Table 1 above to review paid claim data for Audit Type: contract compliance, Cross Platform Drug Audit, Data Mining, Duplicate Services, High Cost Drug (units), Implant Audits/HCD Invoice Services in-scope under this Schedule prior to the additional supplier being allowed to identify overpayments in these audit types. The 90-day review period will be in additional to the period mentioned under Start Date in table 1.

Definitions.

"**Pass Position**" means the position of Cotiviti as Aetna's overpayment recovery auditor relative to other recovery audit suppliers or Client internal teams. If such position is noted as a "co-1st"or "co-2nd", then Cotiviti will share that position with another supplier or Client internal team, otherwise, Cotiviti shall be the exclusive recovery auditor for its respective Pass Positions.

"**Start Date**" means the number of calendar days after the date a claim is paid by Client until such time as Cotiviti may start auditing, except that for retroactive terminations the Start Date refers to the number of calendar days after the date on which the member's medical eligibility was updated with the retroactive termination.

EXHIBIT B

State Specific Compliance Addendum

Exhibit B is comprised of the individual state specific regulatory compliance addenda containing the legal and contractual language required by the respective state (collectively referred to as the "compliance addenda"). The Parties acknowledge that the Agreement and this Schedule, and the services to be provided thereunder, are subject to mandatory statutory, regulatory, contractual and administrative requirements of federal, state, and local government authorities, including but not limited to, those contained in, or incorporated into, the applicable contract with state and/or federal authorities and compliance addenda. Notwithstanding the preceding sentence, the Parties acknowledge that some of the provisions in the compliance addenda are intended for certain types of providers, suppliers and/or subcontractors, and accordingly, may not apply to Supplier's scope of work given the nature of the Services provided. Accordingly, Supplier is obligated to comply with the terms and conditions of the compliance addenda to the extent appropriate and applicable to the Services provided or delegated under the Agreement.

List of State Specific Addenda included in Exhibit B

1. **Exhibit B-1** Individual Sites Regulatory Compliance Addendum Governing Medicaid and CHIP Services (Aetna Better Health of Michigan)
2. **Exhibit B-2** Individual Sites Regulatory Compliance Addendum Governing Medicare-Medicaid Dual-Eligible Services (Aetna Better Health of Michigan)
3. **Exhibit B-3** Individual Sites Regulatory Compliance Addendum (Florida Medicaid)
4. **Exhibit B-4** Individual Sites Regulatory Compliance Addendum (Kentucky Medicaid)
5. **Exhibit B-5** Individual Sites Regulatory Compliance Addendum (WV Medicaid)
6. **Exhibit B-6** Individual Sites Regulatory Compliance Addendum (New Jersey Medicaid)
7. **Exhibit B-7** Individual Sites Regulatory Compliance Addendum (Pennsylvania Medicaid)
8. **Exhibit B-8** Individual Sites Regulatory Compliance Addendum (Virginia Medicaid)
9. **Exhibit B-9** Individual Sites Regulatory Compliance Addendum Governing Medicaid Services (Aetna Better Health of Illinois)
10. **Exhibit B-10** Individual Sites Regulatory Compliance Addendum Governing Medicare-Medicaid Duals Dual Eligible Services (Aetna Better Health of Illinois)
11. **Exhibit B-11** Individual Sites Regulatory Compliance Addendum (Louisiana Medicaid/CHIP)
12. **Exhibit B-12** Individual Sites Regulatory Compliance Addendum (Ohio Medicaid)
13. **Exhibit B-13** Individual Sites Regulatory Compliance Addendum Governing Medicare-Medicaid Dual-Eligible Services (Aetna Better Health of OH)

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Individual Sites Regulatory Addendum – Signature Page

For Exhibits B-1 and B-2 (the Michigan Compliance Addenda)

1. Subcontractor shall comply with the terms of the attached **Exhibits B-1** and **B-2** to the extent applicable to its Agreement with Aetna Better Health of Michigan Inc. ("Aetna Better Health of Michigan"). In the event of any conflict between the terms of the attached Exhibits **B-1** and **B-2** on the one hand, and any of the other terms of the Agreement, on the other hand, including any other attachments, schedules, exhibits, and/or addenda made part of the Agreement, relating to a term required by state law or regulation, the terms of Exhibits **B-1** and **B-2** shall govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the Michigan Plans.

2. Aetna Better Health of Michigan represents and warrants that it has duly authorized Aetna Life Insurance Company: (a) to enter into this Amendment on Aetna Better Health of Michigan's behalf, and (b) to bind Aetna Better Health of Michigan to the terms and provisions of the Agreement, as modified by the attached **Exhibits B-1** and **B-2**.

3. Aetna Better Health of Michigan's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services (if any) that Subcontractor provides to Members who are eligible and covered under the Michigan Plans. Aetna Better Health of Michigan shall have no duties, obligations, or liabilities under the Agreement stemming from any services or claims that relate to the Members of Aetna life Insurance Company or any other Affiliate of Aetna life Insurance Company.

Cotiviti, LLC COMPANY	**AETNA LIFE INSURANCE**
Jonathan Olefson Jonathan Olefson (Jul 23, 2017)	Marc Marini (Jul 24, 2017)
Authorized Signature	Authorized Signature
Jonathan Olefson	Marc Marini
Print Name	Print Name
General Counsel	Marc Marini
Title	Title
Jul 23, 2017	Jul 24, 2017
Date	Date

AETNA BETTER HEALTH OF MICHIGAN INC.

Beverly Allen
Beverly Allen (Jul 19, 2017)
Authorized Signature

Beverly Allen
Print Name

Executive Director
Title

Jul 19, 2017
Date

Individual Sites Regulatory Compliance Addendum – Exhibit B-1

Regulatory Compliance Addendum

Governing Medicaid and CHIP Services

(Aetna Better Health of Michigan)

This Regulatory Compliance Addendum Governing Medicaid and CHIP Services (the "Michigan Medicaid/CHIP Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under, as applicable, (1) the Comprehensive Health Care Program contract (the "CHCP Contract") between the Michigan Department of Health and Human Services ("MDHHS") and Aetna Better Health of Michigan Inc. ("Company"), or (2) the *MIChild* Contract between MDHHS and Company (the "*MIChild* Contract"), under both of which contracts Company serves as a managed-care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the CHCP Contract and/or *MIChild* Contract.

This Michigan Medicaid/CHIP Addendum is incorporated by reference into the Agreement between Company (or its affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof), and such provider, vendor, contractor, or other entity must comply with the requirements set forth herein to the extent applicable to vendor's services. Note that this Michigan Medicaid/CHIP Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in the policies, procedures, and provider manual of Company (or its affiliate, as the case may be). This Michigan Medicaid/CHIP Addendum and the Agreement may be revised as directed by the State of Michigan (the "State").

For purposes of this Michigan Medicaid/CHIP Addendum, the individuals who are enrolled with Company under the CHCP Contract and/or the *MIChild* Contract will be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Michigan Medicaid/CHIP Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Michigan Medicaid/CHIP Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Michigan Medicaid/CHIP Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under, as applicable, the CHCP Contract or the *MIChild* Contract, and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the CHCP Contract and/or *MIChild* Contract. Except as provided herein, all other provisions of the Agreement not inconsistent with this Michigan Medicaid/CHIP Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Michigan Medicaid/CHIP Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

To the extent applicable to the services provided by vendor under the Agreement, the provider, vendor, contractor, or other entity identified on the first page of the Agreement represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Michigan Medicaid/CHIP Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

A. Definitions and Applicability

1. The requirements set forth below in **Section C** of this Michigan Medicaid/CHIP Addendum ("Additional Requirements Applicable to Contracts and Services Under the CHCP Contract") apply to contracts, Covered Services, and related administrative or health-benefit management services/functions under the CHCP Contract, and the following definitions shall apply with respect to those requirements:

a. "Provider" – A health facility or person that is licensed, certified, or registered under parts 61 to 65 or 161 to 182 of Michigan's Public Health code, 1978 PA 368, as amended, MCL 333.1101 – 333.25211, and that provides healthcare services to Members. [CHCP, "Definition of Terms"]

b. "Subcontractor" – Any person or entity that performs a required, ongoing administrative or health-benefit management function of Company under the CHCP Contract, including without limitation: (1) "Health Benefit Managers," which include any entity that administers, manages, or arranges for the provision of one or more of the healthcare benefits that are covered under the CHCP Contract (including Pharmacy Benefit Managers, Behavioral Health Benefit Managers, and Vision Benefit Managers, but excluding Transportation Subcontractors); (2) "Administrative Subcontractors," which include any entity that performs, on behalf of Company, one or more administrative functions required under the CHCP Contract (including claims payment, third-party liability, delegated credentialing, utilization management, case management, card production, and mailing services); and (3) "Transportation Subcontractors," which include any entity that arranges and/or provides transportation services that are covered under the CHCP Contract (including any

related health-benefit management services related to those transportation services). [CHCP, "Definition of Terms" and CHCP 2.070]

c. "Subcontract" – A written contract between Company and a Subcontractor to perform any of Company's administrative or health-benefit management obligations under the CHCP Contract.

2. The requirements set forth below in **Section D** of this Michigan Medicaid/CHIP Addendum ("Additional Requirements Applicable to Contracts and Services Under the *MIChild* Contract") apply to contracts, Covered Services, and related administrative or health-benefit management services/functions under the *MIChild* Contract, and the following definitions shall apply with respect to those requirements:

a. "Provider" – Those providers contracted with Company's health plan that are responsible for providing health care for Members. [CHCP, "Definition of Terms"]

b. "Subcontractor" – Any person or entity that performs a required, ongoing core function of Company under the *MIChild* Contract, with the exception of medical providers that are included in Company's provider network (which are not considered Subcontractors). In addition, counterparties with which Company contracts for one-time-only functions or services, such as maintenance or insurance protection, are not considered Subcontractors. [CHCP, "Definition of Terms"]

c. "Subcontract" – A written contract between Company and a Subcontractor to perform any of Company's administrative obligations under the *MIChild* Contract, with the exception of medical provider contracts, which are not considered Subcontracts. [CHCP, "Definition of Terms"]

3. The requirements set forth below in **Section B** of this Michigan Medicaid/CHIP Addendum ("General Requirements Applicable to Contracts and Services Under Both the CHCP Contract and the *MIChild* Contract") apply to contracts, Covered Services, and related administrative or health-benefit management services/functions under both the CHCP Contract and the *MIChild* Contract (as the case may be with respect to the particular services provided), and the respective definitions set forth above in this **Section A** shall apply with respect to those requirements.

B. General Requirements Applicable to Contracts and Services Under Both the CHCP Contract and the *MIChild* Contract

1. Compliance with Law. Provider/Subcontractor must be in compliance with all State statutes and federal and local laws and ordinances in providing the services under the Agreement, and shall fulfill the requirements of the CHCP Contract/*MIChild* Contract (as the case may be) and of Title XXI of the Social Security Act that are appropriate to the service or activity delegated, and will be subject to the provisions thereof. [*MIChild* I-F; CHCP 2.212]

2. Media Releases. News releases (including promotional literature and commercial advertisements) pertaining to the Agreement, the CHCP Contract, and/or the *MIChild* Contract, or any related project, must not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State, which Company shall be responsible to attempt to obtain. No results of the activities associated with the Agreement, the CHCP Contract, and/or the *MIChild* Contract are to be released without prior written approval of the State and then only to persons designated. [CHCP 2.031; *MIChild* I-G]

3. Non-discrimination. In the performance of the Agreement, Subcontractor agrees not to discriminate against any employee or applicant for employment, with respect to his or her hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability. Subcontractor further agrees that every Subcontract entered into for the performance related to this Agreement or the CHCP Contract/*MIChild* Contract or any Purchase Order resulting from the CHCP Contract/*MIChild* Contract will contain a provision requiring non-

discrimination in employment, as specified here, binding upon each subcontractor used by Subcontractor. This covenant is required under the Elliot Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101 *et seq.*, and the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101 *et seq.*, and any breach of this provision may be regarded as a material breach of the Agreement, as amended, and the CHCP Contract/*MIChild* Contract. [CHCP 2.201; *MIChild* I-U]

4. Unfair Labor Practices. Under 1980 PA 278, MCL 423.321 *et seq.*, the State must not award a contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled under Section 2 of the Social Security Act. This information is compiled by the United States National Labor Relations Board. Subcontractor, in relation to the Agreement and the CHCP Contract/ *MIChild* Contract, must not enter into a contract with a subcontractor, manufacturer, or supplier whose name appears in this register. Under Section 4 of 1980 PA 278, MCL 423.324, the State may void any contract if, after award of the CHCP Contract/*MIChild* Contract, the name of Subcontractor as an employer or the name of a subcontractor, manufacturer, or supplier of Company or Subcontractor appears in the register. [CHCP 2.202; *MIChild* I-Z]

5. Independent Contractor. The relationship between the State and Company is that of client and independent contractor. Subcontractor shall not be deemed to be an employee, agent, or servant of the State for any reason. [CHCP 2.027; *MIChild* I-Y]

6. Transition Plan. Subcontractor shall cooperate in the event the State requires a transition plan setting forth the specific tasks and schedule to be accomplished by the parties to effect an orderly transition. In the event the State requires the services of Subcontractor as necessary to meet its needs, Subcontractor agrees to reasonably, and with good faith, work with the State and Company. [CHCP 2.172; *MIChild* I-R]

7. Member Hold Harmless. Provider/Subcontractor shall look only to Company for compensation for services rendered to a Member when such services are covered by the Plan. Provider/Subcontractor agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against a Member or person acting on behalf of a Member (other than Company), except to the extent that Copayments, Coinsurances, and Deductibles are specified in the Plan or as permitted pursuant to coordination of benefits. (All Copayments, Coinsurances, and Deductibles shall be applied by Company in accordance with applicable law, including without limitation MCL 500.3515.) Provider/Subcontractor agrees not to maintain any action at law or in equity against a Member to collect sums that are owed by Company to such Provider/Subcontractor under the terms of the Agreement, even in the event Company fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This Section shall survive termination of the Agreement, regardless of the cause of termination and shall be construed to be for the benefit of the Member. This Section is not intended to apply to services provided after this Agreement has been terminated, except as otherwise provided in this Agreement, or to Non-Covered Services. Provider/Subcontractor further agrees that this provision supersedes any oral or written agreement, hereinafter entered into between such Provider/Subcontractor and Member or persons acting on Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement. Any modification, addition, or deletion to the provisions of this Section shall become effective on a date no earlier than sixty (60) days after the State Department of Insurance and Financial Services has received and approved such change. [See generally MI ADC R. 325.6345(2); CHCP 1.022U; *MIChild* II-M.5(c)]

8. Cooperation Regarding Data. Provider/Subcontractor must cooperate with Company so that Company can provide and cooperate with the State in the validation of data, and Provider/Subcontractor must make available all medical records and a sample of data and data collection protocols. [*MIChild* II-W; CHCP 1.042]

9. Company Is Sole Point of Contact. Company shall be the sole point of contact for the State with regard to all contractual matters under the CHCP Contract/*MIChild* Contract, including payment of any and all charges for services that Provider/Subcontractor provides in connection therewith. [*MIChild* I-F; CHCP 2.071]

10. Public Presentations. Provider/Subcontractor must obtain the State's written approval prior to publishing, or making formal public presentations of, statistical or analytical material based on its Enrollees other than as required by statute, regulation, or the CHCP Contract and/or *MIChild* Contract. [*MIChild* II-X; CHCP 1.042(b)]]

11. Marketing Materials. Subcontractor understands and agrees that all written and oral marketing materials and health promotion incentive materials must be approved by the State prior to use. In the event Subcontractor desires to utilize written and oral marketing materials related to its services under the Agreement, Subcontractor shall provide such materials to Company for submission to the State. Upon receipt by the State of a complete request for approval that proposes allowed marketing practices and locations, the State will provide a decision to Company within 30 business days or the request will be deemed approved. The review clock will be tolled while State-requested revisions to materials are being prepared for re-submission. Marketing materials must be available in languages appropriate to the Members being served within the county. All material must be culturally appropriate and available in alternative formats in accordance with the American with Disabilities Act. Subcontractor understands and agrees that the State may impose monetary or restricted enrollment sanctions if Subcontractor engages in prohibited marketing practices or uses marketing materials that have not been approved in writing by the State. Materials must be written at no higher than a 6.9 grade reading level as determined by any one of the following indices:

- Flesch – Kincaid
- Other computer generated readability indices accepted by the State

[CHCP 1.022(CC)(5); MIChild II-S]

12. Additional Provisions. In the event Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement, or in the event you are a Provider, your Agreement with Company hereby incorporates, and you shall ensure that your contracts with any of your downstream subcontractors or providers incorporate, the following requirements:

a. Provider/Subcontractor shall not seek payment from Enrollees for services provided, except for applicable co-payments and deductibles, which may be collected directly from Enrollees. [MI ADC R. 325.6345(2); MI Ins. Code 500.3529(3)]

b. Provider/Subcontractor shall meet applicable licensure or certification requirements. [MI ADC R. 325.6345(3)(a); MI Ins. Code 500.3529(4)(a)]

c. Provider/Subcontractor shall allow appropriate access to records or reports concerning services to Enrollees. [MI ADC R. 325. 6345(3)(b); MI Ins. Code 500.3529(4)(b).]

d. Provider/Subcontractor shall cooperate with Company's quality assurance, quality improvement, and utilization review activities. [MI ADC R. 325. 6345(3)(c); MI Ins. Code 500.3529(4)(c); CHCP 1.022U(1)(b); *MIChild* II-M.5(c)]

e. Pursuant to Title XXI of the Social Security Act, payment under Title XXI shall not be made for services furnished by providers who have been excluded from participation under Title V, Title XVIII, Title XIX, or Title XX of the Social Security Act. [*MIChild* II-J.3; CHCP Change Notice No. 5 (section 9)]

f. In the event of Company's insolvency, Provider/Subcontractor agrees to continue providing services to Members. Company acknowledges that it is required by law to provide a mechanism for appropriate sharing of the continuation of provider services as approved by the Michigan Insurance Commissioner and in no event shall such continuation be solely the responsibility of the provider. [MI Ins. Code 500.3561]

g. Unless this Agreement is terminated for cause, upon termination of this Agreement, Provider/Subcontractor shall continue to furnish Covered Services under the Agreement for a period not to exceed ninety (90) days following termination where the continuation of care is medically necessary and prudent, including without limitation, circumstances such as disability, pregnancy, or life-threatening illness. Provider/Subcontractor shall neither charge nor hold Members financially responsible for any Covered

Services rendered other than for applicable deductibles or copayments, and shall be paid for Covered Services rendered at the rate that is in effect between the parties during the period immediately preceding termination on the bases referenced herein. This subsection shall be construed in favor of the Member, shall survive the termination of this Agreement regardless of the reason for termination, and shall supersede any oral or written agreement to the contrary between Provider/Subcontractor and a Member or a Member's representative. [*MIChild* II-M.5(c) and general member-protection provisions]

h. If applicable, Provider/Subcontractor shall provide for the immediate transfer of Enrollees to another network provider/primary-care provider if the Enrollees' health or safety is in jeopardy. [CHCP 1.022U(1)(c); *MIChild* II-M.5(c)]

i. Provider/Subcontractor shall agree to comply with all applicable State and federal requirements, regulations, and laws, including, but not limited to, rules and regulations of CMS and of any other federal agencies and any State agencies of the State(s) in which Provider/Subcontractor practices. Provider/Subcontractor understands and agrees that CMS and the appropriate State agencies may change or add to such requirements, laws, rules, and regulations from time to time. [See CHCP 1.022; CHCP 2.212; *MIChild* II-B]

j. Provider/Subcontractor shall comply with all reporting requirements for communicable diseases and other health indicators. [*MIChild* II-J(2); CHCP 1.022(F)]

k. Providers/Subcontractors are not prohibited from discussing treatment options with Members that may not reflect Company's position or that may not be covered by Company. Providers/Subcontractors acting within the lawful scope of practice are not prohibited, or otherwise restricted, from advising or advocating on behalf of an Enrollee who is his or her patient regarding: (a) the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (b) any information the Enrollee needs in order to decide among all relevant treatment options; (c) the risks, benefits, and consequences of treatment or non-treatment; (d) the Enrollee'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; (e) Medically Necessary and appropriate care with or on behalf of an Enrollee, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultation or tests, regardless of benefit coverage limitations; (f) the process that Company or any entity contracting with Company uses or proposes to use to deny payment for a health care service; (g) the decision of any managed care plan to deny payment for a health care service; or (h) advocating on behalf of the Enrollee in any grievance or utilization review process or Enrollee authorization process to obtain Covered Services. [CHCP 1.022U(1)(d); *MIChild* II-M.5(c); CHCP FY 2013(13) amendment]

13. Clean Claim. The definition of Clean Claim that is set forth in the Agreement shall additionally include the applicable Michigan statutory requirements set forth in MCL 400.111*i*(2)(a). Company shall pay all Clean Claims in accordance with the terms and requirements set forth in MCL 400.111*i*.

14. Governing Law. Notwithstanding anything to the contrary in the Agreement, the laws of the State of Michigan shall govern the Agreement as it relates to Company and to all Covered Services that Provider provides to Company's Members, regardless of where Provider is located.

C. Additional Requirements Applicable to Contracts and Services Under the CHCP Contract

1. Access to and Ownership of Data. The State is the owner of all data made available by the State to Company or its agents, subcontractors, or representatives under the CHCP Contract. Neither Company nor Provider/Subcontractor shall use the State's data for any purpose other than providing the services under the CHCP Contract, nor will any part of the State's data be disclosed, sold, assigned, leased, or otherwise disposed of to the general public or to specific third parties or commercially exploited by or on behalf of Company or Provider/Subcontractor. No employees of Provider/Subcontractor, other than those on a strictly need-to-know basis, shall have access to the State's data. Provider/Subcontractor will not possess or assert any lien or other right against the State's data. Without

limiting the generality of this Section, Provider/Subcontractor must only use personally identifiable information as strictly necessary to provide the services under the Agreement and the CHCP Contract and must disclose the information only to its employees on a strict need-to-know basis. Provider/Subcontractor must comply at all times with all laws and regulations applicable to the personally identifiable information. The State is the owner of all State-specific data under the CHCP Contract. The State may use the data provided by Provider/Subcontractor, directly or indirectly, for any purpose. The State will not possess or assert any lien or other right against Provider/Subcontractor's data. Without limiting the generality of this Section, the State may use personally identifiable information only as strictly necessary to utilize the services under the CHCP Contract and must disclose the information only to its employees on a strict need-to-know basis, except as provided by law. The State must comply at all times with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property. [CHCP 1.042(B)]

2. Personnel Qualifications. All persons assigned by Subcontractor to the performance of services related to the CHCP Contract must be employees of Subcontractor or its majority-owned (directly or indirectly, at any tier) subsidiaries (or a State-approved subcontractor) and must be fully qualified to perform the work assigned to them. For the purposes of the Agreement and this Michigan Medicaid/CHIP Addendum, independent contractors engaged by Subcontractor solely in a staff augmentation role must be treated by the State as if they were employees of Subcontractor for purposes of the Agreement and the CHCP Contract only; however, the State understands that the relationship between Company and Subcontractor is an independent contractor relationship. Subcontractor's personnel must cooperate with the State and its agents and other contractors including the State's Quality Assurance personnel. As reasonably requested by the State in writing, Subcontractor will provide to the State's agents and other contractors reasonable access to its project personnel, systems, and facilities to the extent the access relates to activities specifically associated with the CHCP Contract will not interfere or jeopardize the safety or operation of the systems or facilities. [CHCP 2.061; 2.066]

3. CHCP Contract Binding. Subcontractor, to the extent it is performing services under the Agreement or related to the CHCP Contract, shall be bound to Company by the terms of the CHCP Contract and shall assume all of the obligations and responsibilities that Company, by the CHCP Contract, assumes toward the State. The State reserves the right to receive copies of and review all Subcontracts, although Company may delete or mask any proprietary information, including pricing, contained in such contracts before providing them to the State. The State's written approval of Subcontractor to perform any obligation under the CHCP Contract shall not relieve Company or Subcontractor of any obligations or performance required under the CHCP Contract. [CHCP 2.073]

4. Confidentiality. [CHCP 2.100–2.105]

a. Company and Provider/Subcontractor each acknowledge that the other possesses and will continue to possess confidential information that has been developed or received by it. As used in this Section, "Confidential Information" means all non-public proprietary information of Company or Provider/Subcontractor (other than Confidential Information of the State as defined below) which is marked confidential, restricted, proprietary, or with a similar designation. "Confidential Information" of the State means any information that is retained in confidence by the State (or otherwise required to be held in confidence by the State under applicable federal, State, and local laws and regulations) or that, in the case of tangible materials provided to Company or Provider/Subcontractor by the State under its performance under the CHCP Contract, is marked as confidential, proprietary, or with a similar designation by the State. "Confidential Information" excludes any information (including the CHCP Contract) that is publicly available under the Michigan FOIA.

b. Company and Provider/Subcontractor will each use at least the same degree of care to prevent disclosing to third parties the Confidential Information of the other as it employs to avoid unauthorized disclosure, publication or dissemination of its own confidential information of like character, but in no event less than reasonable care. Neither Company nor Provider/Subcontractor will (i) make any use of the Confidential Information of the other except as contemplated by this Michigan Medicaid/CHIP Addendum, (ii) acquire any right in or assert any lien against the Confidential Information of the other, or (iii) if requested to do so, refuse for any reason to promptly return the other party's Confidential Information to the other party. Each party will limit disclosure of the other party's Confidential Information to employees and

subcontractors who must have access to fulfill the purposes of the Agreement and the CHCP Contract. Disclosure to, and use by, a subcontractor is permissible where (A) use of a subcontractor is authorized under the Agreement and the CHCP Contract, (B) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the subcontractor's scope of responsibility, and (C) the subcontractor is obligated in writing to maintain the State's, Company's, and/or Provider/Subcontractor's Confidential Information in confidence. At the State's request, any employee of Provider/Subcontractor having access or continued access to the State's Confidential Information may be required to execute an acknowledgment that the employee has been advised of Company's and Provider/Subcontractor's obligations under this section and of the employee's obligation to Company or Provider/Subcontractor, as the case may be, to protect the Confidential Information from unauthorized use or disclosure. Promptly upon termination or cancellation of this Agreement or the CHCP Contract for any reason, Provider/Subcontractor must certify to the State and/or Company that Provider/Subcontractor has destroyed all Confidential Information of the State or Company.

c. Notwithstanding the foregoing, the provisions of subsections 4.a and 4.b above will not apply to any particular information that the State, Company, or Provider/Subcontractor can demonstrate (i) was, at the time of disclosure to it, in the public domain; (ii) after disclosure to it, is published or otherwise becomes part of the public domain through no fault of the receiving party; (iii) was in the possession of the receiving party at the time of disclosure to it without an obligation of confidentiality; (iv) was received after disclosure to it from a third party who had a lawful right to disclose the information to it without any obligation to restrict its further disclosure; or (v) was independently developed by the receiving party without reference to Confidential Information of the furnishing party. Furthermore, the provisions of subsections 4.a and 4.b above will not apply to any particular Confidential Information to the extent the receiving party is required by law to disclose the Confidential Information, provided that the receiving party (i) promptly provides the furnishing party with notice of the legal request, and (ii) assists the furnishing party in resisting or limiting the scope of the disclosure as reasonably requested by the furnishing party.

d. Nothing contained in this Section shall be construed as obligating a party to disclose any particular Confidential Information to the other party, or as granting to or conferring on a party, expressly or impliedly, any right or license to the Confidential Information of the other party.

e. The parties' respective obligations under this Section must survive the termination or expiration of this Michigan Medicaid/CHIP Addendum, the Agreement, and the CHCP Contract for any reason.

[CHCP 2.100–105]

5. Inspection of Work Performed. Subcontractor acknowledges and agrees that the State's authorized representatives must at all reasonable times, and with ten (10) days' prior written request, have the right to enter Subcontractor's premises, or any other places, where the services performed under this Agreement or the CHCP Contract are being performed, and must have access, upon reasonable request, to interim drafts of any deliverables related to this Agreement or the CHCP Contract, or work-in-progress. Upon ten (10) days' prior written notice and at all reasonable times, the State's representatives must be allowed to inspect, monitor, or otherwise evaluate the work being performed and to the extent that the access will not reasonably interfere or jeopardize the safety or operation of the systems or facilities. Subcontractor must provide all reasonable facilities and assistance for the State's representatives. [CHCP 2.111]

6. Examination of Records. For seven (7) years after Subcontractor provides any work under the CHCP Contract or the Agreement (the "Audit Period"), the State and/or federal representatives may examine and copy any of Subcontractor's books, records, documents, and papers pertinent to establishing Subcontractor's compliance with the CHCP Contract and with applicable laws and rules. The State and/or federal representatives must notify Subcontractor twenty (20) days before examining Subcontractor's books and records. This provision also applies to the books, records, accounts, documents, and papers, in print or electronic form, of any parent, affiliated, or subsidiary organization of Subcontractor performing services in connection with the Agreement or CHCP Contract. [CHCP 2.112]

7. Retention of Records. Subcontractor must maintain at least until the end of the Audit Period all pertinent financial and accounting records (including time sheets and payroll records, and information pertaining to the Agreement or CHCP Contract, equipment, and commodities provided under the Agreement or CHCP Contract) pertaining to the Agreement or CHCP Contract according to generally accepted accounting principles and other procedures specified in this Section. Financial and accounting records must be made available, upon request, to the State and/or federal representatives at any time during the Audit Period. If an audit, litigation, or other action involving Subcontractor's records is initiated before the end of the Audit Period, the records must be retained until all issues arising out of the audit, litigation, or other action are resolved or until the end of the Audit Period, whichever is later. [CHCP 2.113]

8. Audit Resolution. If necessary, Company, Subcontractor, and the State will meet to review each audit report promptly after issuance. Subcontractor will respond, either directly to the State, or indirectly through Company, to each audit report in writing within thirty (30) days from receipt of the report, unless a shorter response time is specified in the report. Company, Subcontractor, and the State must develop, agree upon, and monitor an action plan to promptly address and resolve any deficiencies, concerns, and/or recommendations in the audit report. [CHCP 2.114]

a. If the audit demonstrates any errors in the documents provided to the State or Company, then the amount in error will be reflected as a credit or debit on a future pay cycle and in subsequent pay cycles until the amount is paid or refunded in full. [CHCP 2.115]

b. In addition to other available remedies, if the difference between the payment received and the correct payment amount is greater than 10%, then Subcontractor must pay all of the reasonable costs of the audit. [CHCP 2.115]

9. Warranties and Representations. [CHCP 2.120–2.127] Subcontractor represents and warrants that, with respect to the services that it is contractually required to provide to Company under the Agreement:

a. It is capable in all respects of fulfilling and must fulfill all of its obligations under the Agreement and the CHCP Contract. The performance of all obligations must be provided in a timely, professional, and workman-like manner and must meet the performance and operational standards required under the Agreement or CHCP Contract.

b. The CHCP Contract (Appendices, Attachments and Exhibits) identifies the equipment and software and services necessary to perform and to operate in compliance with the CHCP Contract requirements and other standards of performance.

c. It is the lawful owner or licensee of any Deliverable (as defined by the CHCP Contract) licensed or sold to the State or Company or developed by Subcontractor under the CHCP Contract, and Subcontractor has all of the rights necessary to convey to the State the ownership rights or licensed use, as applicable, of any and all Deliverables. None of the Deliverables provided by Subcontractor to the State under the CHCP Contract, nor their use by the State, will infringe the patent, copyright, trade secret, or other proprietary rights of any third party.

d. If, under the CHCP Contract or the Agreement, Subcontractor procures any equipment, software, or other Deliverable for the State (including equipment, software and other Deliverables manufactured, re-marketed or otherwise sold by Subcontractor under Subcontractor's name), then in addition to Subcontractor's other responsibilities with respect to the items in the CHCP Contract, Subcontractor must assign or otherwise transfer to the State or its designees, or afford the State the benefits of, any manufacturer's warranty for the Deliverable.

e. Subcontractor's signatory has the power and authority, including any necessary corporate authorizations, necessary to enter into this Agreement, on behalf of Subcontractor.

f. It is qualified and registered to transact business in all locations where required.

g. Neither Subcontractor nor any affiliates, nor any employee of either, has, must have, or must acquire, any contractual, financial, business, or other interest, direct or indirect, that would conflict in any manner or degree with Subcontractor's performance of its duties and responsibilities to the State under the CHCP Contract or otherwise create an appearance of impropriety with respect to the award or performance of the CHCP Contract. Subcontractor must notify Company and the State about the nature of the conflict or appearance of impropriety within two days of learning about it.

h. Neither Subcontractor nor any affiliates, nor any employee of either, has accepted or must accept anything of value based on an understanding that the actions of Subcontractor or its affiliates or employees on behalf of the State would be influenced. Subcontractor must not attempt to influence any State employee by the direct or indirect offer of anything of value.

i. Neither Subcontractor nor any affiliates, nor any employee of either, has paid or agreed to pay any person, other than bona fide employees and consultants working solely for Subcontractor or the affiliate, any fee, commission, percentage, brokerage fee, gift, or any other consideration, contingent upon or resulting from the award or making of the CHCP Contract.

j. All financial statements, reports, and other information furnished by Subcontractor (if any) to the State in connection with the award of the CHCP Contract fairly and accurately represent the business, properties, financial condition, and results of operations of Subcontractor as of the respective dates, or for the respective periods, covered by the financial statements, reports, other information. Since the respective dates or periods covered by the financial statements, reports, or other information provided to the State (if any), there have been no material adverse change in the business, properties, financial condition, or results of operations of Subcontractor.

k. All written information furnished to Company or the State by or for Subcontractor in connection with the CHCP Contract, is true, accurate, and complete, and contains no untrue statement of material fact or omits any material fact necessary to make the information not misleading.

l. It is not in material default or breach of any other contract or agreement that it may have with the State or any of its departments, commissions, boards, or agencies. Subcontractor further represents and warrants that it has not been a party to any contract with the State or any of its departments that was terminated by the State or the department within the previous five years for the reason that Subcontractor failed to perform or otherwise breached an obligation of the CHCP Contract.

m. If any of the certifications, representations, or disclosures relating to Subcontractor (if any) made in Company's original bid response change after the award of the CHCP Contract, the Subcontractor is required to report those changes immediately.

[CHCP 2.120–127]

10. Consequences for Breach of Warranties and Representations. In addition to any remedies available in law, if Subcontractor breaches any of the warranties contained in Subsection C.9 above, the breach may be considered as a default in the performance of a material obligation of the Agreement, as amended. [CHCP 2.128]

11. Workplace Safety and Discriminatory Harassment. In performing services under the Agreement and related to the CHCP Contract, and to the extent Subcontractor has employees in the State of Michigan, Subcontractor must comply with the Department of Civil Services Rule 2-20 regarding Workplace Safety and Rule 1-8.3 regarding Discriminatory Harassment. In addition, Subcontractor must comply with Civil Service regulations and any applicable agency rules provided to the Contractor. For Civil Service Rules, see www.mi.gov/mdcs/0,1607,7-147-6877---,00.html. [CHCP 2.203]

12. Disclosure of Litigation and Other Events. Subcontractor must disclose any material criminal litigation, investigations, or proceedings involving Subcontractor (and each of its subcontractors) or any of its officers or directors or any litigation, investigations, or proceedings under the Sarbanes-Oxley Act. In addition, Subcontractor (and each of its subcontractors) must notify Contractor of any material civil litigation, arbitration, or proceeding that arises during the term of the Agreement or the CHCP Contract and extensions, to which Subcontractor (or, to the extent Subcontractor is aware, any subcontractor) is a party, and that involves: (i) disputes that might reasonably be expected to adversely affect the viability or financial stability of Subcontractor or any of its subcontractors; or (ii) a claim or written allegation of fraud against Subcontractor or, to the extent Subcontractor is aware, any of its subcontractors by a governmental or public entity arising out of their business dealings with governmental or public entities. Subcontractor must disclose in writing to Company any litigation, investigation, arbitration, or other proceeding (collectively, "Proceeding") within thirty (30) days of its occurrence. Details of settlements that are prevented from disclosure by the terms of the settlement may be annotated. Information provided to the State from Subcontractor's publicly filed documents referencing its material litigation will be deemed to satisfy the requirements of this Section. If any Proceeding disclosed to the State under this Section, or of which the State otherwise becomes aware, during the term of the CHCP Contract would cause a reasonable party to be concerned about: (i) the ability of Company, Subcontractor, or any of Subcontractor's subcontractors to continue to perform pursuant to the CHCP Contract or the Agreement according to their terms and conditions, or (ii) whether Company, Subcontractor, or any of Subcontractor's subcontractors in performing services for the State is engaged in conduct that is similar in nature to conduct alleged in the Proceeding, which conduct would constitute a breach of the Agreement or CHCP Contract or a violation of State law, regulations, or public policy, then Subcontractor must provide Company and the State all reasonable assurances requested by the State to demonstrate that: (a) Company, Subcontractor, and any of Subcontractor's subcontractors will be able to continue to perform the CHCP Contract according to its terms and conditions, and (b) Company, Subcontractor, or any of Subcontractor's subcontractors have not and will not engage in conduct in performing the services that is similar in nature to the conduct alleged in the Proceeding. Subcontractor must make the following notifications in writing: (1) Subcontractor must notify Company within fifteen (15) days of Subcontractor becoming aware that a change in its ownership or officers has occurred, or is certain to occur, or a change that could result in changes in the valuation of its capitalized assets in the accounting records; (2) Subcontractor must notify Company within fifteen (15) days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership or officers; and (3) Subcontractor must notify Company within thirty (30) days whenever changes to company affiliations occur. In each of the aforementioned instances, Company shall notify the State as required. [CHCP 2.231]

13. Contract with the State. Subcontractor understands and agrees that upon a good-faith termination of the CHCP Contract, the State may assume, at its option, the Agreement between Company and Subcontractor, and may further pursue completion of the services/Deliverables under the CHCP Contract by replacement contract or otherwise as the State may in its sole judgment deem advantageous to the State. [CHCP 2.157]

14. False Claims. Subcontractor must comply with all applicable provisions of the federal False Claims Act and Michigan Medicaid False Claims Act. Actions taken to comply with the federal and State laws specifically include, but are not limited, to complying with and adopting Company's policies regarding the detection and prevention of waste, fraud, and abuse. [CHCP 1.022(L)(9)]

15. Annual Report. Subcontractor shall provide necessary information for Company to submit its required annual report, which shall include disclosure of applicable civil litigation. [CHCP 1.042]

16. State Approval of Subcontractors. Subcontractor understands and agrees that the State has the right of approval of Health Benefit Managers and Type A Transportation Subcontractors (as defined herein) and to require Company to replace any Heath Benefit Managers and Type A Transportation Subcontractors found, in the reasonable judgment of the State, to be unacceptable. The State's request will be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's request will be based on good-faith reasons. [2.072]

17. Services/Deliverables Covered. For all services/Deliverables to be provided by Company (and its Subcontractors) under the CHCP Contract, the State will not be obligated to pay any amounts in addition to the amounts set forth in the CHCP Contract. [CHCP 2.043]

18. Insurance.

a. Subcontractor shall purchase and maintain the insurance coverage as described in this Section in connection with the performance of work under the Agreement. The insurance must protect the State from claims that may arise out of or result from the Subcontractor's performance of services under the CHCP Contract, whether the services are performed by the Subcontractor or by anyone directly or indirectly employed by it, or by anyone for whose acts it may be liable. The Subcontractor waives all rights against the State, its departments, divisions, agencies, offices, commissions, officers, employees, and agents for recovery of damages to the extent these damages are covered by the insurance policies the Subcontractor is required to maintain under the CHCP Contract. All insurance coverage provided relative to the CHCP Contract must be PRIMARY and NON-CONTRIBUTING to any comparable liability insurance (including self-insurance) carried by the State. The insurance must be written for not less than any minimum coverage specified in this Section or required by law, whichever is greater. The insurers selected by Subcontractor must have an A.M. Best rating of A or better, or as otherwise approved in writing by the State, or if the ratings are no longer available, with a comparable rating from a recognized insurance rating agency. All policies of insurance required must be issued by companies that have been approved to do business in the State. Where specific limits are shown in this Section, they are the minimum acceptable limits. If Subcontractor's policy contains higher limits, the State must be entitled to coverage to the extent of the higher limits. [CHCP 2.131]

b. Subcontractor must furnish to Company certificates of insurance verifying insurance coverage or providing satisfactory evidence of self-insurance as required in this Section (the "Certificates"). The Certificates must be on the standard "accord" form or equivalent. All Certificates are to be prepared and submitted by the insurance provider. All Certificates must contain a provision indicating that coverages afforded under the policies WILL NOT BE CANCELLED, MATERIALLY CHANGED, OR NOT RENEWED without 30 days' prior written notice, except for 10 days for non-payment of premium, having been given to the Director of Purchasing Operations, Department of Management and Budget. The notice must include reference to the CHCP Contract. Subcontractor shall provide Company with information necessary for Company to evidence to the State upon request, and not less than 20 days before the insurance expiration date every year, that the State and its agents, officers, and employees are listed as additional insureds under each commercial general liability and commercial automobile liability policy. In the event the State approves the representation of the State by the insurer's attorney, the attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan. [CHCP 2.133]

c. Subcontractor must maintain all required insurance coverage throughout the term of the Agreement and any extensions and, in the case of claims-made Commercial General Liability policies, must secure tail coverage for at least three years following the expiration or termination for any reason of Agreement. The minimum limits of coverage specified above are not intended, and must not be construed, to limit any liability or indemnity of Subcontractor to any indemnified party or other persons. Subcontractor is responsible for all deductibles with regard to the insurance. If the Subcontractor fails to pay any premium for required insurance, or if any insurer cancels or significantly reduces any required insurance without the State's written consent, Company reserves the right to be made whole by Subcontractor in the event the State pays the premium or procures similar insurance coverage from another company or companies and deducts any part of the cost from any payment due to Company, or in the event that the State requires Company to pay that cost upon demand by the State. [CHCP 2.133]

d. For purposes of this Section, the following definitions shall apply [see CHCP 2.070]:

(i) Transportation Subcontractor: An entity that arranges or arranges and provides transportation services covered under the CHCP Contract under a written subcontract with Company in the following categories:

I. Type A Transportation Subcontractors perform Health Benefit Management services for the transportation benefit. These Subcontractors do not directly

provide the transportation benefit, but rather subcontract with other entities to provide the actual transportation.

II. Type B Transportation Subcontractors arrange and provide the transportation services, such as social or religious agencies that provide transportation to covered services.

(ii) Health Benefit Manager: An entity that arranges for the provision of health services covered under the Agreement, with the exclusion of transportation. Health Benefit Managers include, but are not limited to, Pharmacy Benefit Managers, Behavioral Health Benefit Managers, and Vision Benefit Managers.

(iii) Administrative Subcontractors are entities that perform, for Company, administrative functions required by this Agreement such as claims payment, delegated credentialing, and card production and mailing services, in the following categories:

I. Type A Administrative Subcontractors perform administrative functions for Company dealing with claims payment, third party liability, or other functions involving payment decisions.

II. Type B Administrative Subcontractors perform administrative functions relating to medical decisions such as credentialing, utilization management, or case-management.

III. Type C Administrative Subcontractors perform miscellaneous administrative functions required by this Agreement that do not involve payment or medical decisions. This type of administrative Subcontractor includes but is not limited to identification card production and mailing services.

e. Insurance Requirements for Health Benefit Managers and Type A Transportation Subcontractors [see CHCP 2.132]:

(i) Commercial General Liability with the following minimum coverage:

$2,000,000 General Aggregate Limit other than Products/Completed Operations

$2,000,000 Products/Completed Operations Aggregate Limit

$1,000,000 Personal & Advertising Injury Limit

$1,000,000 Each Occurrence Limit

Subcontractor must list the State, its departments, divisions, agencies, offices, commissions, officers, employees, and agents as ADDITIONAL INSUREDS on the Commercial General Liability certificate. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

(ii) If a motor vehicle is used to provide services or products under the Agreement, Subcontractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Subcontractor's business for bodily injury and property damage as required by

law. Subcontractor must list the State, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

(iii) Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Subcontractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Subcontractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur. Any certificates of insurance received must also provide a list of states where the coverage is applicable. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

(iv) Employers liability insurance with the following minimum limits:

$100,000 each accident

$100,000 each employee by disease

$500,000 aggregate disease

(v) Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by Subcontractor's employees acting alone or in collusion with others, in a minimum amount of one million dollars ($1,000,000.00) with a maximum deductible of fifty thousand dollars ($50,000.00).

(vi) Umbrella or Excess Liability Insurance in a minimum amount of five million dollars ($5,000,000.00), which must apply, at a minimum, to the insurance required in Subsection 19(c)(i) (Commercial General Liability) above.

(vii) Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: one million dollars ($1,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

f. Insurance Requirements for Type A – Administrative Subcontractors dealing with payment decisions [see CHCP 2.132]:

(i) If a motor vehicle is used to provide services or products under the Agreement, Subcontractor must have vehicle liability insurance on any auto including owned, hired, and non-owned vehicles used in Subcontractor's business for bodily injury and property damage as required by law. The Subcontractor must list the State, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

(ii) Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Subontractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification,

Subcontractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur. Any certificates of insurance received must also provide a list of states where the coverage is applicable. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

(iii) Employers liability insurance with the following minimum limits:

$100,000 each accident

$100,000 each employee by disease

$500,000 aggregate disease

(iv) Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by the Subcontractor's employees, acting alone or in collusion with others, in a minimum amount of one million dollars ($1,000,000.00) with a maximum deductible of fifty thousand dollars ($50,000.00).

(v) Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: three million dollars ($3,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

g. Insurance Requirements for Type B Administrative Subcontractors dealing with medical decisions [see CHCP 2.132]:

(i) If a motor vehicle is used to provide services or products under the Agreement, Subcontractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Subcontractor's business for bodily injury and property damage as required by law. Subcontractor must list the State, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

(ii) Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of Subcontractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Subcontractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur. Any certificates of insurance received must also provide a list of states where the coverage is applicable. Subcontractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

(iii) Employers liability insurance with the following minimum limits:

$100,000 each accident

$100,000 each employee by disease

$500,000 aggregate disease

(iv) Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: one million dollars ($1,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

h. Insurance Requirements for Type B Transportation Subcontractors: Type B Transportation Subcontractors must verify that individuals providing the transportation have secured appropriate insurance coverage as required by law. The subcontract with the Type B Transportation Subcontractor should require these Type B Transportation Subcontractors to obtain a letter of understanding with the individual providing the transportation that attests that the individual has appropriate insurance coverage. [CHCP 2.132]

19. Additional Provisions. In the event Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement, or in the event you are a Provider, your Agreement with Company hereby incorporates, and you shall ensure that your contracts with any of your downstream subcontractors or providers incorporate, the requirements set forth above in Subsection B.12 of this Michigan Medicaid/CHIP Addendum, as well as the following additional requirements:

a. Providers must be prohibited from seeking payment from an Enrollee for any covered services provided to that Enrollee within the terms of the CHCP Contract and must be required to look solely to the Subcontractor or Company, as applicable, for compensation for services rendered. No cost sharing or deductibles can be collected from Enrollees unless approved in writing by Company. [CHCP 1.022U(1)(a)]

b. Providers must be required to meet Medicaid accessibility standards as defined in the CHCP Contract. [CHCP 1.022U(1)(f)]

c. Providers must provide for continuity of treatment in the event a provider's participation terminates during the course of an Enrollee's treatment by that provider. [CHCP 1.022U(1)(g)]

d. If the Plan utilizes co-payments for the Covered Service, providers must be prohibited from denying services to an Enrollee who is eligible for the services due to the Enrollee's inability to pay the co-payment. [CHCP 1.022U(1)(h)]

e. Hospital contracts must contain a provision that mandates the hospital to comply with all medical record requirements contained within 42 C.F.R. §§ 456.101–456.145 [CHCP 1.022U(1)(i); FY 2012 amendment No. 18]

f. In accordance with Section 1932(b)(7) of the Social Security Act as implemented by Section 4704(a) of the Balanced Budget Act, Provider/Subcontractor may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as an "any willing provider" law, as it does not prohibit Provider/Subcontractor from limiting provider participation to the extent necessary to meet the needs of the enrollees. This provision also does not interfere with measures established by the Provider/Subcontractor that are designed to maintain quality and control costs consistent with the responsibility of the organization. If Provider/Subcontractor declines to include providers in its network, Provider/Subcontractor must give the affected providers written notice of the reason for the decision. [CHCP 1.022U(2)]

g. In order for Company to comply with its contractual and legal obligations, Provider agrees to permit Subcontractor, Company, any federal or State agency having jurisdiction over Provider's provision of services to the Plan, the U.S. Department of Health and Human Services, and/or any accrediting organization to conduct periodic site evaluations of Provider's facilities, offices, and records. Upon Company's written

request, Provider shall provide Company with a copy of the written response to any questions or comments posed by the agencies listed in the preceding sentence. [See generally CHCP 2.110]

h. During regular business hours and upon reasonable notice and demand, Company and/or Subcontractor shall have access to, and the right to audit and obtain copies of, Provider records within the possession of or reasonably accessible to, or under the control of Provider that are related to the services provided under this Agreement. Unless applicable statutes or regulations require a longer time period, Company and/or Subcontractor shall have such access during the term of this Agreement and for seven (7) years following its termination. All Provider records requested by Company and/or Subcontractor shall be provided within no more than seven (7) days from the date such request is made, except in the case of an audit or site visit by Company and/or Subcontractor where records or copies of records shall be provided at the time of the audit or site visit. Provider's refusal to grant access to Provider records as requested by Company and/or Subcontractor or as required by any federal or State law or regulations shall constitute a breach of this Agreement and may result in the imposition of sanctions including termination and/or financial penalties. [CHCP 2.110]

i. Providers shall comply with State and federal law and Company policy to enable Members to make decisions concerning their medical care, including the right to accept or refuse medical treatment and the right to formulate, at the Members option, advanced directives. [CHCP 1.022(L)(7)]

D. Additional Requirements Applicable to Contracts and Services Under the *MIChild* Contract

1. Disclosure of Ownership. Subcontractor must cooperate with Company so that Company can fulfill its requirements under the *MIChild* Contract to (a) disclose and submit ownership information between Company and any person with control or ownership of five percent (5%) or more in a Subcontract, and (b) supply upon request of the federal or State government a description of the transactions (if any) between Company and any person with control or ownership of five percent (5%) or more in a Subcontractor. [*MIChild* I-F]

2. Insurance. Subcontractors shall maintain insurance coverage as specified in this Section and shall provide proof, upon the State's request and if applicable, of medical professional liability insurance in amounts consistent with Company's provider network standards for similar professionals. Specifically, the Subcontractor shall purchase and maintain such insurance as will protect it from the claims set forth below that may arise out of or result from the Subcontractor's operations under the *MIChild* Contract, whether such operations are by the Subcontractor or by anyone directly or indirectly employed by it, or by anyone for whose acts any of them may be liable:

a. Claims under workers' compensation, disability benefit, and other similar employee benefit act. A non-resident Subcontractor shall have insurance for benefits payable under the State's Workers' Disability Compensation Law for any employee resident of and hired in the State, and as respects any other employee protected by workers' disability compensation laws of any other state the Subcontractor shall have insurance or participate in a mandatory state fund to cover the benefits payable to any such employee. Subcontractor shall provide workers' compensation insurance for all its employees working in the State, unless its employees are covered by the workers' compensation protection afforded by Company. Any Subcontract executed with a person or entity not having the requisite workers' compensation coverage will be considered void by the State. [*MIChild* I-P.1]

b. Claims for damages because of bodily injury, occupational sickness or disease, or death of its employees. [*MIChild* I-P.2]

c. Claims for damages because of bodily injury, sickness or disease, or death of any person other than its employees, subject to limits of liability of not less than $1,000,000 each occurrence and, when applicable, $2,000,000 annual aggregate, for non-automobile hazards and as required by law for automobile hazards. [*MIChild* I-P.3]

d. Claims for damages because of injury to or destruction of tangible property, including loss of use resulting therefrom, subject to a limit of liability of not less than $50,000 each occurrence for non-automobile hazards and as required by law for automobile hazards. [*MIChild* I-P.4]

e. Insurance for subparagraphs (c) and (d) non-automobile hazards on a combined single limit of liability basis shall not be less than $1,000,000 each occurrence and, when applicable, $2,000,000 annual aggregate. [*MIChild* I-P.5]

f. The insurance noted in this section shall be written for not less than any limits of liability herein specified or required by law, whichever is greater. [*MIChild* I-P.8]

3. Minority Owned Business. Provider/Subcontractor shall not discriminate against minority-owned and women-owned businesses and businesses owned by persons with disabilities in any subcontracting. Any such discrimination will be a material breach of contract. [*MIChild* I-U.2]

4. Conduct of Personnel. The Subcontractor shall notify the Company if Subcontractor, or any of its subcontractors, officers, directors, or key personnel have ever been convicted of a felony, or any crime involving moral turpitude, including but not limited to fraud, misappropriation, or deception. Subcontractor shall promptly notify Company of any criminal litigation, investigations, or proceedings that have arisen or may arise involving the Subcontractor or any of the Subcontractor's subcontractors, or any of the foregoing entities' then-current officers or directors during the term of the *MIChild* Contract and three years thereafter. [*MIChild* I-DD.1]

5. Litigation. Subcontractor shall notify Company, as promptly as possible, of any civil litigation, arbitration, proceedings, or judgments that have arisen or may arise against it or its subcontractors during the term of the *MIChild* Contract or within three years thereafter, that involve (1) products or services similar to those provided to the State under the *MIChild* Contract and that either involve a claim in excess of $250,000 or that otherwise may affect the viability or financial stability of the Subcontractor, (2) a claim or written allegation of fraud against the Subcontractor or its subcontractors hereunder, arising out of their business activities, or (3) a claim or written allegation that the Subcontractor or its subcontractors hereunder violated any federal, state, or local statute, regulation, or ordinance. In addition, multiple lawsuits and/or judgments against the Subcontractor or its subcontractors in an amount less than $250,000 shall be disclosed to Company to the extent they affect the financial solvency and integrity of the Subcontractor or its subcontractors. Subcontractor must cooperate with Company to provide to the State all reasonable assurances requested by the State to demonstrate that: (a) Subcontractor or its subcontractors hereunder will be able to continue to perform under the *MIChild* Contract in accordance with its terms and conditions, or (b) the Subcontractor or its subcontractors will not engage in conduct in performing services under under the *MIChild* Contract that is similar in nature to the conduct alleged in any such litigation, arbitration, or other proceedings. [*MIChild* I-DD]

6. Record Retention and Examination. Subcontractor shall maintain all pertinent financial and accounting records and evidence pertaining to the Agreement and the *MIChild* Contract in accordance with generally accepted principles of accounting and other procedures specified by the State. Subcontractor shall permit the State or the U.S. Department of Health and Human Services or any of their identified agents access to the Subcontractor's facilities being utilized at any reasonable time, during normal business hours, to observe the operation of the program. Furthermore, Subcontractor shall retain all books, records, or other documents relevant to the Agreement and the the *MIChild* Contract for six (6) years after final payment, at its cost, and federal auditors and any persons duly authorized by the State shall have full access to and the right to examine and audit any of said material during said period. If an audit is initiated prior to the expiration of the six (6) year period, and extends past that period, all documents shall be maintained until the audit is completed. Subcontractor shall assure, as a condition of any sale or transfer of ownership of Subcontractor, that the new purchaser or owner maintains the above-described books, records, or other documents for any unexpired portion of the six (6) year period after final payment under the Agreement and the the *MIChild* Contract, or Subcontractor shall otherwise maintain said records as the State may direct. Subcontractor shall, if it ceases business operations, maintain the records as the State may direct. [*MIChild* I-I]

7. Provider Care. In the event Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement, or in the event you are a Provider, your Agreement with Company hereby incorporates, and you shall ensure that your contracts with any of your downstream subcontractors or providers

incorporate, the requirements set forth above in Subsection B.12 of this Michigan Medicaid/CHIP Addendum, as well as the following additional requirements:

a. Providers shall be responsible for providing primary and specialty care to Enrollees. In addition, primary care providers are responsible for initiating referrals for specialty care and maintaining the Enrollee's medical record, which shall include documentation of all services provided. [*MIChild* II-M.5(a)]

b. Provider/Subcontractor shall ensure that: (i) Enrollees will not be denied a covered service or availability of a facility or provider identified in the *MIChild* Contract; and (ii) providers will not intentionally segregate *MIChild* Enrollees in any way from other persons receiving health care services. [*MIChild* II-M.5(b)]

c. Any medical records, required data, reports of services, or reports on complaints, grievances, quality, or utilization issues for Enrollees must be made available to Company. [*MIChild* II-M.5(b)]

d. Providers shall accept the Enrollees along with all other Enrollees of Company, and not segregate them in any way or treat them in a location or manner different from other Enrollees. [*MIChild* II-M.5(b)]

e. To the extent reasonably possible and as applicable, Provider/Subcontractor must require its contracted providers to maintain medical records of all medical services received by the Enrollees and assist with Company's record maintenance/confidentiality/access requirements under the *MIChild* Contract. [*MIChild* II-Y]

Individual Sites Regulatory Compliance Addendum - Exhibit B-2

Regulatory Compliance Addendum

Governing Medicare-Medicaid Dual-Eligible Services

(Aetna Better Health of Michigan)

This Addendum Governing Medicare-Medicaid Dual-Eligible Services (the "Duals Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under, as well as the provision of any administrative or health-benefit management services/functions that relate to:

(1) the *Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services, In Partnership with the State of Michigan and Aetna Better Health of Michigan Inc.*, issued on August 1, 2016 (the "Three-Way Contract"); and

(2) any predecessor or successor contracts to, or amendments of, any of the foregoing;

to the extent that the terms and conditions of this Duals Addendum are applicable to Provider's services and obligations under the Agreement. The Three-Way Contract governs the program known as the MI Health Link Duals Demonstration (the "Demonstration"), under which Aetna Better Health of Michigan Inc. ("Company") serves as an "Integrated Care Organization."

This Duals Addendum is incorporated by reference into the Agreement between Company (or its affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing the Agreement, as identified on the first page of the Agreement (the "Provider"), and Provider must comply with the requirements set forth herein. Note that this Duals Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement, in the Three-Way Contract, and in the policies, procedures, and provider manual of Company (or its affiliate, as the case may be). This Duals Addendum and the Agreement may be revised as directed by the State of Michigan (the "State") and/or by the Centers for Medicare and Medicaid Services ("CMS").

For purposes of this Duals Addendum, Company may be referred to as "ICO" or "MCO" (a/k/a integrated care organization and managed care organization, respectively), and the individuals who are enrolled with Company under the Demonstration may be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Duals Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Duals 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 Duals

Addendum will govern and control with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and the Demonstration; provided, however, that if there is a conflict between any of the terms of the Agreement, including this Duals Addendum, and the Three-Way Contract, then the terms of the Three-Way Contract will govern and control. Except as provided herein, all other provisions of the Agreement not inconsistent with this Duals Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Duals Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Three-Way Contract and the remainder of the Agreement.

Provider acknowledges and agrees that the provisions of this Duals Addendum, and the Medicare Services Exhibit to the Agreement, shall apply equally to any employees (temporary or permanent), partners, individual practitioners, independent contractors, subcontractors, downstream entities, or related entities of Provider that provide Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, or that provide administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and the Demonstration, to the extent that those provisions are applicable to the services that the aforementioned individuals and/or entities actually provide. Provider furthermore represents and warrants that, with respect to all such aforementioned individuals and/or entities: (a) Provider's contracts therewith shall be in writing and shall specify, as applicable, the delegated activities and reporting responsibilities of those individuals and/or entities; (b) Provider shall cause those individuals and/or entities to comply with this Duals Addendum and the Medicare Services Exhibit to the Agreement, and with all applicable State and federal laws and regulations (including applicable CMS instructions and directives), to the extent applicable to the services that those individuals and/or entities actually provide; and (c) Provider either has the authority to bind those individuals and/or entities in that regard (and shall provide written evidence of same to MCO upon request), or shall include in Provider's contracts with such individuals and/or entities all of the contractual and legal obligations and duties imposed upon Provider in the Agreement in order for such individuals and/or entities to comply with applicable State and federal laws and regulations, including applicable CMS instructions and directives (and again Provider shall provide written evidence of same to MCO upon request). This includes any such aforementioned individuals and/or entities that may perform services under the Agreement in Provider's offices, on behalf of Provider, for which Provider bills such services under the Agreement. To the extent that the State and/or CMS requires additional provisions to be included in Provider's contracts with such aforementioned individuals and/or entities, Provider shall amend its contracts in conformance therewith. [42 C.F.R. § 422.504]

All provisions of this Duals Addendum that by their nature should survive termination of the Agreement and/or termination of Provider's provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, or, as the case may be, Provider's provision of administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and the Demonstration, shall survive such termination.

REQUIREMENTS FOR THE DEMONSTRATION

A. Michigan State Requirements

The State and/or the Michigan Department of Health and Human Services ("MDHHS") requires that specific terms and conditions be incorporated into the Agreement because the Agreement is a contract between a health maintenance organization and a provider. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the following requirements with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract and the Demonstration:

1. Provider shall look only to MCO for compensation for services rendered to an Enrollee when such services are covered by the Plan. Provider agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against an Enrollee or person acting on behalf of an Enrollee (other than MCO), except to the extent that copayments, coinsurances, and/or deductibles are specified in the Plan or as permitted pursuant to coordination of benefits. (All copayments, coinsurances, and deductibles shall be applied by MCO in accordance with applicable law, including without limitation MCL 500.3515.) Provider agrees not to maintain any action at law or in equity against an Enrollee to collect sums that are owed by MCO to such Provider under the terms of the Agreement, even in the event MCO fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This provision shall survive termination of the Agreement, regardless of the cause of termination and shall be construed to be for the benefit of the Enrollee. This provision is not intended to apply to services provided after this Agreement has been terminated, except as otherwise provided in this Agreement, or to non-Covered Services. Provider further agrees that this provision supersedes any oral or written agreement, hereinafter entered into between such Provider and Enrollee or persons acting on Enrollee's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement. [MI ADC R. 325.6345(2); MI Ins. Code 500.3529(3)]

2. Provider shall meet applicable licensure or certification requirements. [MI ADC R. 325.6345(3)(a); MI Ins. Code 500.3529(4)(a)]

3. Provider shall allow appropriate access to records or reports concerning services to Enrollees. [MI ADC R. 325. 6345(3)(b); MI Ins. Code 500.3529(4)(b)]

4. Provider shall cooperate with MCO's quality assurance activities. [MI ADC R. 325. 6345(3)(c); MI Ins. Code 500.3529(4)(c)]

5. In the event of MCO's insolvency, Provider shall continue to provide services to Enrollees. MCO acknowledges that it is required by law to provide a mechanism for appropriate sharing of the continuation of Provider services as approved by the Michigan Insurance Commissioner and in no event shall such continuation be solely the responsibility of Provider. [MI Ins. Code 500.3561]

6. The definition of Clean Claim that is set forth in the Agreement shall additionally include the applicable Michigan statutory requirements set forth in MCL 400.111*i*(2)(a). Company shall pay all Clean Claims in accordance with the terms and requirements set forth in MCL 400.111*i*.

7. Notwithstanding anything to the contrary in the Agreement, the laws of the State of Michigan shall govern the Agreement as it relates to Company and to all Covered Services that Provider provides to Company's Members, regardless of where Provider is located, unless Michigan law is preempted by federal law consistent with Section 5.1.13.2 of the Three-Way Contract.

B. Medicare Requirements

Without limiting any obligation of Provider under the Agreement, Provider shall comply with, and shall cause its Downstream Entities to comply with, the requirements set forth in this **Section B** (including any delegated function-specific Schedules appended hereto) and the Medicare Services Exhibit to the Agreement (the "Medicare Services Exhibit") with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider), as applicable, that relate to those Covered Services or to the Three-Way Contract and the Demonstration (the "Medicare Services"). The term "Downstream Entities" shall have the meaning that is ascribed to it in the Medicare Services Exhibit. Furthermore, with respect to the requirements set forth in this **Section B**: (a) the term "Provider" shall include Provider's permanent and temporary employees; (b) the Members who are dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration shall collectively be referred to as the "Medicare Members"; and (c) the managed-care plan that MCO offers under the Three-Way Contract and the Demonstration shall be referred to as the "Medicare Plan." Provider furthermore acknowledges and agrees that all terms of Medicare Services Exhibit shall apply equally to services provided in connection with the Three-Way Contract and the Demonstration, even if Medicare Services Exhibit only refers to Medicare Advantage products. The requirements set forth in this **Section B** (including Medicare Services Exhibit) shall be governed by federal laws, regulations, and agency requirements that are applicable to the Medicare program. In the event that changes to such governing laws, regulations, or agency requirements occur, the new law, regulation, or agency requirement that is applicable to the Medicare program shall supersede to the extent required by any such later required changes.

Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. PROVIDER OBLIGATIONS.

A. Compliance; Cooperation. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement, including without limitation any activities and responsibilities that MCO is delegating to Provider in connection with the Three-Way Contract and the Demonstration, will be performed consistent with and will comply with MCO's contractual and legal obligations and duties imposed on MCO under the Three-Way Contract and under applicable Medicare laws, regulations, rules, and other directions of CMS. Upon request, Provider shall immediately provide to MCO any information that is required by MCO to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. Provider agrees to cooperate with and participate in internal and external review procedures necessary to allow MCO to process Medicare appeals and grievances in accordance with Medicare laws, regulations, and CMS instructions. [42 C.F.R. § 422.504(i)(3)(iii)]

B. Compliance Program and Anti-Fraud Initiatives. Provider shall (and shall cause its Downstream Entities, if any, 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 the Medicare Plan. Such compliance program shall be appropriate to the organization and operations of Provider and Provider's Downstream Entities and shall include:

(1) Written compliance policies and standards of conduct that are comparable to Aetna's compliance policies/Aetna Code of Conduct and articulate the entity's commitment to comply with federal and state laws, ethical behavior, and compliance program operations. Provider will disseminate either Aetna's compliance policies/Aetna Code of Conduct or comparable versions to Provider's employees, officers, and Downstream Entities within ninety (90) days of hire/contracting, when updates are made, and annually thereafter.

(2) Reporting mechanisms communicated to Provider's employees and Downstream Entities for their use in adhering to the expectation that Provider, its employees, and its Downstream Entities report potential non-compliance or FWA issues (internally and to MCO, as applicable) and understand their obligation to report. Provider must publicize the reporting methods to Provider employees and Downstream Entities along with a no-tolerance policy for retaliation or retribution for good-faith reporting.

(3) Completion of CMS's Medicare Learning Network® "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training" by Provider employees, officers, and Downstream Entities initially within ninety (90) days of hire/contracting and at least annually thereafter, unless exempt from such training under relevant CMS regulations. Training may be completed in one of two ways: (1) by completing the general compliance and FWA training modules located on the CMS Medicare Learning Network; or (2) by downloading, viewing or printing the content of the then current CMS standardized training modules from the CMS website to incorporate into Provider's and/or Downstream Entity's organization's existing compliance training materials/systems. The CMS training content may not be changed but Provider and/or its Downstream Entities may add to it to cover topics specific to its organization.

(4) Processes to oversee and ensure that Provider and Provider's Downstream Entities maintain compliance with processes to oversee and ensure that: (1) Provider and Provider's Downstream Entities maintain compliance with CMS compliance program requirements, and (2) Provider's Downstream Entities perform Medicare Services consistent with this Agreement and the agreement between Provider and such Downstream Entities. Provider's oversight under this Agreement shall include: (1) imposition of disciplinary actions, as needed, to ensure employee compliance with CMS compliance program requirements, and (2) implementation of corrective actions (up to and including contract termination), as needed, with respect to its Downstream Entities to ensure Downstream Entity compliance with applicable CMS requirements, including the CMS compliance program requirements, this Agreement, and Provider's contract with the Downstream Entity.

(5) Retention of evidence showing that Provider and Provider's Downstream Entities complied with the requirements set forth in this Section. Such evidence must be maintained for at least the period of time specified in Section B.1.F. hereof and shall be made available to MCO and CMS, upon request. Provider shall complete attestations in the form and manner requested by Company to confirm its compliance with this section on an annual basis.

[Chapter 21 of the Medicare Managed Care Manual]

C. Federal Fund Obligations. Provider understands and agrees that payments received by MCO for the Medicare Plan from CMS pursuant to the Three-Way Contract, as well as payments that Provider receives from MCO for performing services and functions under the Agreement, constitute the receipt of federal funds. As a result, Provider, by entering into the Agreement and the terms of this Duals 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. [Section 120 of Chapter 11 of the Medicare Managed Care Manual]

D. Continuation of Services. In the event the Three-Way Contract terminates or MCO becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized 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 the Agreement, regardless of the reason for termination, including the insolvency of MCO, and shall supersede any oral or written agreement between Provider and a Medicare Member. [42 C.F.R. § 422.504(g)(2)(i) and (ii)]

E. Policies, Programs & Procedures. Provider agrees to comply with MCO's policies and procedures (which MCO shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Duals Addendum, and the Three-Way Contract and Demonstration. Provider agrees to comply with MCO's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies MCO may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that an MCO 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. [Section 100.4 of Chapter 11 of the Medicare Managed Care Manual]

F. Maintenance of Records. Provider, on behalf of itself and its Downstream Entities (if any), shall preserve records applicable to Medicare Members and/or to MCO's participation in the Three-Way Contract and Demonstration, for the longer of: (i) the period of time required by state and federal law, or (ii) ten (10) years. 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, if any, containing data used by MCO to calculate Medicare medical loss ratios ("MLRs") for MCO's Medicare products and/or evidence needed by MCO 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 MCO to CMS. This provision shall survive the termination of the Agreement, regardless of the cause of termination. [42 C.F.R. § 422.504(i)(2)(i)(ii) and 42 C.F.R. § 422.2480(c)(1)]

G. Contracts with Excluded Entities. Provider understands and agrees that no person or entity that provides Medicare Services, directly or indirectly, for MCO's Medicare Plan, may be an individual or entity excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person or entity will be employed by or utilized by Provider or by any of Provider's Downstream Entities to directly or indirectly perform Medicare Services under this Agreement. 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 Services Administration System for Awards Management (collectively, "Exclusion Lists") to ensure that no persons or entities employed by or utilized by Provider or by any of Provider's Downstream Entities are included on such Exclusion Lists. Provider agrees to review the Exclusion Lists prior to initially hiring, appointing, or contracting with any new employee, temporary employee, or Downstream Entity, and at least once per month thereafter to confirm that such persons and entities are not included on such Exclusion Lists. Provider agrees that if any such person or entity utilized by Provider to directly or indirectly perform Medicare Services under this Agreement appears on an

Exclusion List and/or is excluded from participation in any federally-funded health program, Provider will immediately remove the employee, temporary employee, or Downstream Entity from any work related directly or indirectly to MCO's Medicare Plan, and take all corrective actions required under applicable laws, rules, or regulations. In the event Provider or any employee, temporary employee, or Downstream Entity of Provider that directly or indirectly performs Medicare Services under this Agreement is listed in an Exclusion List after the Effective Date of this Duals Addendum, MCO shall have the right, in its sole discretion and judgment, to terminate Provider's participation in MCO's Medicare Plan in accordance with the Agreement or to disqualify any such person or entity on the Exclusion List from providing any part of the Medicare Services. [42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6) & 1001.1901 and Section 50.6.8 of the Medicare Managed Care Manual]

H. Offshore Services. Provider is prohibited from performing, and is prohibited from engaging or paying any individual or entity to perform, any services for the Medicare Plan if Provider or such individual or entity, as the case may be, 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 MCO, in its sole discretion and judgment, agrees in advance and in writing to the provision of such Offshore Services by Provider and/or such individual or entity. Provider furthermore agrees that MCO has the right to audit Provider and/or such individual or entity prior to the provision of Offshore Services for the Medicare Plan. Additionally, Provider represents and warrants that it does not and will not permit any Medicare Member's protected health information (PHI), or any other information that MCO or Provider has obtained in connection with the Three-Way Contract and Demonstration, to be accessible by any individual or entity that is physically located outside of one of the fifty United States or one of the United States Territories without prior written notice to MCO and without MCO's prior written approval of same. In the event that MCO agrees in advance and in writing to the provision of Offshore Services that involve Medicare Member protected health information (PHI), such Offshore Services are subject to CMS reporting within thirty (30) days of: (1) performing, or contracting to perform, such Offshore Services, and (2) any time Provider changes the Offshore Services being performed. [CMS Memo dated July 23, 2007 on "Sponsor Activities Performed Outside of the United States" and CMS Questions and Answers dated September 20, 2007 on "Sponsor Activities Performed Outside of the United States"]

I. Submission of Encounter Data. Provider hereby acknowledges that MCO 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 MCO and to provide MCO with all such information in such form and manner as requested by MCO. Provider agrees to immediately notify MCO if any encounter data that Provider submitted to MCO for Medicare Members is inaccurate, incomplete, or erroneous, and to cooperate with MCO to correct erroneous encounter data to ensure MCO's compliance with Medicare laws, rules, and regulations and CMS instructions. [42 C.F.R. § 422.310]

J. Certification of Data. Provider recognizes that MCO 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 MCO by its contracted providers and Downstream Entities. To the extent that Provider generates and/or compiles and provides to Company (either on its own or through its Downstream Entities) any data that MCO, in turn, submits to CMS, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete, and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by MCO. [42 C.F.R. § 422.504(l)(3)]

K. Medicare Member Complaints. Provider agrees to cooperate with MCO in resolving any Medicare Member complaints related to coverage or the provision of Covered Services. MCO 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 MCO in the

required time. Provider shall use best efforts to resolve complaints in a fair and equitable manner. [42 C.F.R. § 422.562(a)]

L. Enrollment as Medicare Provider. To the extent that Provider prescribes drugs covered under Medicare Part D to Medicare Members who have Medicare prescription drug ("MA-PD") coverage offered by MCO, Provider agrees to comply with the requirements set forth in 42 C.F.R. § 423.120(c)(6), including without limitation the requirement that Provider be enrolled in Medicare in an approved status in order for its prescriptions to be covered under Medicare Part D. [42 C.F.R. § 423.120(c)(6)]

M. Home Infusion Drugs. The following provisions shall only apply to Provider if Provider dispenses to a Medicare Member home infusion drugs that are covered under Medicare Part D and the Medicare Member has MA-PD coverage offered by MCO ("Home Infusion Drug"):

1. With respect to Home Infusion Drugs, MCO will pay clean claims (as defined in 42 C.F.R. § 423.520(b)) submitted by Provider on behalf of Medicare Members within 14 days for electronic claims and within 30 days for claims submitted otherwise. [42 C.F.R. § 423.505(i)(3)(vi)]

2. Home Infusion Drugs will be reimbursed (as applicable) in accordance with a fee schedule, or the third-party pricing source (*e.g.*, Medi-Span) otherwise agreed upon as set forth in the Agreement or Provider's agreement with MCO's Pharmacy Benefit Manager ("PBM"). [42 C.F.R. § 423.505(i)(3)(viii)(B)]

3. If a prescription drug pricing standard is used for reimbursement of Home Infusion Drugs, updates to such a standard will occur not less frequently than once every 7 days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the Home Infusion Drug. [42 C.F.R. § 423.505(i)(3)(viii)(A)]

4. In accordance 42 C.F.R.§ 423.120(c)(3), Provider agrees to submit claims for Home Infusion Drugs to MCO or its PBM whenever the Medicare Member's ID card is presented or is on file at the Provider, unless the Medicare Member expressly requests that the claim not be submitted to MCO or its PBM. [42 C.F.R.§ 423.120(c)(3)]

5. Provider must submit claims for Home Infusion Drugs in real time by means of point of service claims adjudication systems in compliance with CMS standards. [42 C.F.R. § 423.505(b)(17)]

6. Provider must provide Medicare Members with access to the negotiated prices (as defined in 42 C.F.R. § 423.100) for Home Infusion Drugs to Members. [42 C.F.R. § 423.104(g)(1)]

7. Provider must charge/apply the correct cost-sharing amount to the Medicare Member for Home Infusion Drugs. [42 C.F.R. § 423.104]

8. At the time of purchase by a Medicare Member, Provider must inform the

Medicare Member of any differential between the price of the Home Infusion Drug being dispensed and the price of the lowest priced generic version of that Home Infusion Drug available from Provider, unless the Home Infusion Drug being dispensed is the lowest priced generic version of that Home Infusion Drug. [42 C.F.R. § 423.132]

9. Provider agrees to ensure that the professional services and ancillary supplies necessary for Home Infusion Drugs are in place before dispensing Home Infusion Drugs to a Medicare Member in his/her place of residence. [42 C.F.R. § 423.120(a)(4)(iii)]

10. Provider agrees to provide delivery of Home Infusion Drugs within 24 hours of a Medicare Member's discharge from an acute setting, or later if so prescribed. [42 C.F.R. § 423.120(a)(4)(iv)]

11. Provider shall submit to MCO (not PBM) claims for equipment, supplies, and professional services associated with Home Infusion Drugs dispensed by Provider to a Medicare Member that are covered under Medicare Part C.

N. Marketing. Consistent with federal laws, regulations, and agency requirements applicable to the Medicare program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare Members, 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. [2017 Medicare Marketing Guidelines, as amended from time to time]

O. Non-Covered Services. Provider shall not hold a Medicare Member financially responsible for payment of a service not covered under the MCO's Medicare Plan ("Non-Covered Service") unless the Medicare Member has received a pre-service organization determination notice of denial from MCO before such services are rendered. Provider acknowledges and agrees that if Provider renders Non-Covered Services to a Medicare Member who has not received a pre-service organization determination notice of denial from MCO, the Provider must hold the Medicare Member harmless for the Non-Covered Services and cannot charge the Medicare Member any amount beyond the normal cost-sharing amounts (*i.e.*, copayments, coinsurance, and/or deductibles). With respect to those Non-Covered Services that are clearly listed as exclusions under the MCO's Medicare Plan, a pre-service organization determination is not required in order for Provider to hold the Medicare Member financially liable for such Non-Covered Services. [CMS Memo dated May 5, 2014 "Improper Use of Advance Notices of Non-coverage"]

P. Dual-Eligible Hold Harmless. Provider acknowledges and agrees that Medicare 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 furthermore agrees that it will not collect Cost Sharing Amounts from Medicare Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the MCO'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. [42 C.F.R. § 422.504(i)(3)(i)]

2. OTHER TERMS.

A. MCO shall not pay any amounts beyond the amounts set forth in the applicable Services and

Compensation Schedule (or other analogous compensation schedule appended to the Agreement), 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. Furthermore, Provider and MCO each acknowledge and agree that payments under the Medicare program to providers, suppliers, and MCO 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, Provider and MCO agree that, in the event of a Medicare Payment Adjustment, MCO's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. MCO shall adjust payments under the Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjust payments to Provider for Covered Services until the earlier of (i) the discontinuation of the Medicare Payment Adjustment, or (ii) the replacement of the Medicare Payment Adjustment by a subsequent Medicare Payment Adjustment.

B. Pursuant to Section B.1.J. of this Duals Addendum, Provider certifies that the diagnosis codes submitted to MCO for Medicare Members that MCO is required to submit to CMS will be accurate, complete, and truthful (the "Certification"). Provider acknowledges and agrees that MCO may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to MCO 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, "diagnosis code" shall mean an International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) code or its successor.

C. Requirements Under the Demonstration Three-Way Contract

The Three-Way Contract requires that specific additional terms and conditions be incorporated into the Agreement. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the requirements set forth in this **Section C** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract and the Demonstration. With respect to the requirements set forth in this **Section C**, any capitalized terms that are used but not defined herein shall have the meanings that are ascribed to them in the Three-Way Contract. Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. The delegated activities and reporting requirements for which Provider is responsible are contained in the Agreement. Provider shall ensure that it and its downstream and related entities perform all such delegated activities and reporting requirements in compliance with 42 C.F.R. §§ 422.504, 423.505, 438.6(l), and 438.230(b)(1), as applicable. [Appendix C.1 of Three-Way Contract]

2. HHS, the Comptroller General, MDHHS, MDHHS's office of Inspector General, the Medicaid Fraud Control Unit of the Michigan State Police, the Michigan Auditor General, and their designees, and other state and federal agencies with monitoring authority related to Medicare and Medicaid, have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation, of Provider and its downstream and related entities, and the foregoing rights to inspect, evaluate, and audit any pertinent information for any particular contract period shall exist for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later. [Appendix C.2 of Three-Way Contract]

3. Provider and its downstream and related entities shall not hold Enrollees liable for payment of any fees that are the obligation of MCO. [Appendix C.3.1 of Three-Way Contract]

4. Any services or other activity performed by Provider and/or its downstream and related entities shall be performed in accordance with the MCO's contractual obligations to CMS and MDHHS. [Appendix C.3.2 of Three-Way Contract]

5. MCO shall revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS, the MDHHS, or the MCO determine that Provider and/or its downstream and related entities have not performed their delegated activities or reporting requirements satisfactorily. [Appendix C.3.4 of Three-Way Contract]

6. The performance of Provider and its downstream and related entities under the Agreement will be monitored by MCO on an ongoing basis and MCO may impose corrective action as necessary. [Appendix C.3.5 of Three-Way Contract]

7. Provider and its downstream and related entities agree to safeguard Enrollee privacy and confidentiality of Enrollee health records. [Appendix C.3.6 of Three-Way Contract]

8. Provider and its downstream and related entities must comply with all federal and state laws, regulations and CMS instructions. [Appendix C.3.7 of Three-Way Contract]

9. To the extent that Provider and/or its downstream and related entities provide credentialing of medical providers under the Agreement:

   A. The credentials of medical professionals affiliated with the Provider and/or its downstream and related entities will be reviewed by MCO; or

   B. The credentialing process will be reviewed and approved by MCO and MCO shall audit the credentialing process on an ongoing basis.

   [Appendix C.4 of Three-Way Contract]

10. To the extent that MCO has delegated the selection of providers under the Agreement to Provider or its downstream and related entities, MCO retains the right to approve, suspend, or terminate that arrangement. [Appendix C.5 of Three-Way Contract]

11. Unless otherwise permitted under the Three-Way Contract or by the consent of CMS and MDHHS, neither MCO nor Provider has the right to terminate the Agreement without cause, and Provider shall

provide at least 60 calendar days' notice to MCO and assist with transitioning Enrollees to new providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the MCO or Enrollee. [Appendix C.6 of Three-Way Contract]

12. MCO shall provide a written statement to Provider of the reason or reasons for termination for cause. [Appendix C.7 of Three-Way Contract]

13. MCO is obligated to pay Provider under the terms of the Agreement, which includes a prompt-payment provision that has been developed and agreed to by both MCO and Provider. [Appendix C.8.1 of Three-Way Contract]

14. Provider and its downstream and related entities shall provide all services under the Agreement in a Culturally Competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds. [Appendix C.8.2 of Three-Way Contract]

15. Provider and its downstream and related entities shall abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. [Appendix C.8.3 of Three-Way Contract]

16. Provider and its downstream and related entities shall ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas. [Appendix C.8.4 of Three-Way Contract]

17. Provider and its downstream and related entities shall maintain Enrollee records and information in an accurate and timely manner. [Appendix C.8.5 of Three-Way Contract]

18. Provider and its downstream and related entities shall ensure timely access by Enrollees to the records and information that pertain to them. [Appendix C.8.6 of Three-Way Contract]

19. Provider and its downstream and related entities shall not hold Enrollees liable for Medicare Part A and B cost sharing, and all Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees. [Appendix C.8.7 of Three-Way Contract]

20. Provider and its downstream and related entities shall ensure that their EMTALA obligations are fulfilled as required by law and the Agreement and must not create any conflicts with any hospital actions required to comply with EMTALA. [Appendix C.8.8 of Three-Way Contract]

21. Provider and its downstream and related entities, including without limitation all primary care providers, shall not close or otherwise limit acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees. [Appendix C.8.9 of Three-Way Contract]

22. MCO shall not refuse to contract or pay Provider for the provision of Covered Services solely because Provider has in good faith:

(a) Communicated with or advocated on behalf of one or more of the prospective, current, or former patients of Provider or its downstream and related entities regarding the provisions, terms, or requirements of the MCO's health benefit plans as they relate to the needs of such patients; or

(b) Communicated with one or more of the prospective, current, or former patients of Provider or its downstream and related entities with respect to the method by which such provider is compensated by the MCO for services provided to the patient.

[Appendix C.8.10 of Three-Way Contract]

23. Provider and its downstream and related entities are not required to indemnify MCO for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against MCO based on MCO's management decisions, utilization review provisions, or other policies, guidelines, or actions. [Appendix C.8.11 of Three-Way Contract]

24. Provider and its downstream and related entities shall comply with all MCO's requirements and MCO Policies for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services. [Appendix C.8.12 of Three-Way Contract]

25. MCO shall notify Provider in writing of modifications in payments, modifications in Covered Services, or modifications in MCO's procedures, documents, or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 30 calendar days before the effective date of such modification unless such other date for notice is mutually agreed upon between MCO and Provider or unless such change is mandated by CMS or MDHHS without 30 calendar days' prior notice. [Appendix C.8.13 of Three-Way Contract]

26. Provider and its downstream and related entities shall not bill Enrollees for charges for Covered Services other than pharmacy co-payments, if applicable. [Appendix C.8.14 of Three-Way Contract]

27. No payment shall be made by MCO to Provider for a Provider Preventable Condition as defined in 42 C.F.R. § 447.26(b). [Appendix C.8.15 of Three-Way Contract]

28. As a condition of payment, Provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by MCO. Provider shall comply with such reporting requirements to the extent Provider directly furnishes services. [Appendix C.8.16 of Three-Way Contract]

29. Provider shall ensure coverage for its practice twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable. [Appendix C.8.17 of Three-Way Contract]

30. MCO shall monitor and ensure that all Utilization Management activities provided by Provider comply with all provisions of the Three-Way Contract with CMS and MDHHS, and Provider and its downstream and related entities shall cooperate with and utilize MCO's Quality Assurance Program. [Section 2.13.3.1.4.2 of Three-Way Contract]

31. Provider shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. Contracts or arrangements with First Tier, Downstream and Related Entities shall not include incentive plans that include a specific payment to Provider or its downstream and related entities as an inducement to deny, reduce, delay, or limit specific, Medically Necessary Services, and (a) Provider and/or its downstream and related entities shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate, and (b) MCO shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate. Nothing herein shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared-risk agreements that are made with respect to physicians or physician groups or that are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services, and equipment provided or authorized by another physician or health care provider, comply with Paragraph 32 immediately below. [Section 5.1.7.2 and Appendix C.9 and C.11 of Three-Way Contract]

32. MCO shall not impose a financial risk on Provider or its downstream and related entities for the costs of medical care, services or equipment provided or authorized by another Physician or health care provider unless such contract includes specific provisions with respect to the following:

A. Stop-loss protection;

B. Minimum patient population size for the Physician or Physician group; and

C. Identification of the health care services for which the Physician or Physician group is at risk.

[Appendix C.12 of Three-Way Contract]

33. All contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites that provide services must include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. [Appendix C.13 of Three-Way Contract]

34. Nothing shall be construed to restrict or limit the rights of MCO to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious nonmedical providers. [Appendix C.14 of Three-Way Contract]

35. Provider shall meet all terms and requirements of the Three-Way Contract that are applicable to Provider. [Section 2.7.7.1 of Three-Way Contract]

36. Provider and its downstream and related entities shall allow MCO to access the medical records of Enrollees.

37. Provider will collaborate with MCO on documentation systems reporting, communications, policies, and any other matters necessary for any readiness review required under the Three-Way Contract. [Section 2.2.1.3 of Three-Way Contract]

38. Provider must notify MCO within fourteen (14) calendar days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "**Legal Proceedings**") involving Provider or any of its its downstream and related entities, or any officer or director of Provider or any of its its downstream and related entities, that arises during the term of the Agreement, including: any criminal Legal Proceeding; any parole or probation Legal Proceeding; any Legal Proceeding under the Sarbanes-Oxley Act; or any civil Legal Proceeding that involves a claim that might reasonably be expected to adversely affect Provider's viability or financial stability, that involves a governmental or public entity's claim or written allegation of fraud, or that involves a Legal Proceeding involving any license that Provider is required to possess in order to perform under this Agreement or the Three-Way Contract. [Section 2.1.2.1.10 of Three-Way Contract]

39. Provider shall submit to MCO the organizational chart of Provider. [Section 2.2.3.4 of Three-Way Contract]

40. Provider shall collaborate with MCO, as requested and required under the Three-Way Contract, on activities relating to the Care Bridge, the Care Coordination Platform, and the Integrated Care Bridge Record. [Section 2.5 of Three-Way Contract]

41. As requested and required under the Three-Way Contract, Provider shall actively participate as a member of the Integrated Care Team and shall collaborate with the Enrollee and other members of the Integrated Care Team to ensure performance of the following tasks, as may be applicable:

    a. Development, implementation, and revision of the Individual Integrated Care and Supports Plan ("**IICSP**") according to the Person-Centered Planning Process and the Enrollee's stated goals including making whatever accommodations are appropriate for individuals whose disabilities create obstacles to full participation with the ICT.

    b. Participation in the Person-Centered Planning Process at the Enrollee's discretion to develop the IICSP.

    c. Collaboration with other ICT members to ensure the Person-Centered Planning Process is maintained.

    d. Assisting the Enrollee in meeting his/her goals.

    e. Monitoring and ensuring that Provider's part of the IICSP is implemented in order to meet the Enrollee's goals.

    f. Updating the ICBR as needed pertinent to the Provider's role on the ICT.

    g. Reviewing assessment, test results, and other pertinent information in the ICBR.

    h. Addressing transitions of care when a change between care settings occur.

    i. Ensuring continuity of care requirements are met.

j. Monitoring for issues related to quality of care and quality of life.

k. Adherence to an Enrollee's determination about the appropriate involvement of his or her medical providers and caregivers, according to HIPAA and, for individuals in substance use disorder treatment, C.F.R. 42, Part 2.

[Section 2.5.2.5 of Three-Way Contract]

42. Provider must maintain physical sites that are accessible to all Enrollees, and must comply with and apply the United States Supreme Court's *Olmstead* decision which requires that Enrollees be served in the most integrated setting appropriate to their needs. [Section 2.7.2.3 of Three-Way Contract]

43. Provider shall be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollee with disabilities (both congenital and acquired disabilities), or other special population served by the MCO. [Section 2.7.2.5 of Three-Way Contract]

44. To the extent that Provider is multilingual, Provider shall understand and comply with its obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Provider to meet these obligations. [Section 2.7.2.6 of Three-Way Contract]

45. Provider shall maintain a strong understanding of disability, recovery, and resilience cultures, and Long Term Supports and Services. [Section 2.7.2.8 of Three-Way Contract]

46. To the extent that Provider provides Medicare-covered services, Provider shall be enrolled as a Medicare provider in order to submit claims for reimbursement or otherwise participate in the Medicare program. To the extent that Provider provides Medicaid-covered services, Provider shall be enrolled in the Michigan Medicaid program, if such enrollment is required by MDHHS's rules or policy, in order to submit claims for reimbursement or otherwise participate in the Michigan Medicaid program. [Section 2.7.2.10 of Three-Way Contract]

47. To the extent applicable, Provider must ensure that nursing facility beds will be held for the Enrollee for hospital and therapeutic leave days pursuant to the Michigan Medicaid Provider Manual/Nursing Facility Coverages/Special Placements and Agreement. [Section 2.7.2.11 of Three-Way Contract]

48. Provider and its facilities must be appropriately licensed or certified, as applicable, if required pursuant to the Michigan Public Health Code, 1978 PA 368, as amended, MCL 333.1101-333.25211. [Section 2.7.2.12 of Three-Way Contract]

49. Provider shall notify MCO immediately if Provider has lost any required license or state or federal approval, or been excluded from participation in federal health care programs by the OIG of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 *et seq.*, or has been terminated from participation under Medicare, the Michigan Medicaid program, or another state's Medicaid program, except as permitted under 42 C.F.R.§ 1001.1801 and § 1001.1901. [Sections 2.7.3.5.1 and 5.3.4 of Three-Way Contract]

50. If Provider is a Primary Care Provider, Provider must be available to see patients a minimum of twenty (20) hours per week per practice location, as per state Medicaid policy. [Section 2.7.3.6.4 of Three-Way Contract]

51. Provider shall comply with and meet all applicable MCO standards for licensure, certification, and credentialing. [Section 2.7.3.11.4 and 2.7.3.11.5 of Three-Way Contract]

52. Provider shall not engage in any practice with respect to any Enrollee that constitutes unlawful discrimination under any state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90. [Section 2.7.3.11.6 of Three-Way Contract]

53. As requested by MCO, Provider shall submit disclosures in accordance with 42 C.F.R. § 455 Subpart B and 42 C.F.R. § 1002.3. [Section 2.7.3.11.7 of Three-Way Contract]

54. Provider may not seek payment for a Provider Preventable Condition, and Provider shall, as a condition of payment from MCO, comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by MCO and/or MDHHS. [Section 2.7.4.7.3 of Three-Way Contract]

55. Provider shall comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal-related healthcare programs, including Medicare, Medicaid, and/or Children's Health Insurance Program, and shall upon MCO's request provide all required disclosures in accordance with 42 C.F.R. § 455, 42 C.F.R. § 1002.3, and otherwise. [Section 2.7.5.8 and 5.1.6 of Three-Way Contract]

56. To the extent applicable, Provider must (a) afford Enrollees the opportunity and assistance with filing a Grievance, Appeal, or State Fair Hearing, and must permit an Enrollee to request continuation of benefits if the Enrollee files an Appeal or a request for a State Fair Hearing within specified timeframes, (b) use the the existing Part D Appeals Process, and (c) remain compliant with all state and federal laws, regulations, and policies governing the Appeal and State Fair Hearing processes, and all statutory and regulatory timelines related thereto, including the requirements for both standard and expedited requests. If any Grievance or Appeal is filed with Provider, Provider must immediately forward it to MCO. [Section 2.7.7.4 and 2.10.1.1 of Three-Way Contract]

57. Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees. [Section 2.8.1.5 of Three-Way Contract]

58. Provider must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) as outlined in the Three-Way Contract, and must maintain capacity to deliver services in a manner that accommodates the needs of Enrollees. [Section 2.8.1.6 and 2.8.12 of Three-Way Contract]

59. Upon MCO's request, Providers must provide the following information: (a) its name, address, and telephone number; (b) its areas of special experience, skills, and training, including any expertise in treating persons with physical disabilities, chronic illness, HIV/AIDS, or persons with serious mental

illness; persons who are homeless; persons who are deaf, hard-of-hearing, blind, and/or visually impaired; or persons with co-occurring disorders; (c) its office hours, including the name of any provider site open after 5:00 p.m. (Eastern Time) on weekdays and/or open on weekends; (d) its cultural and linguistic capabilities, including languages spoken by the Provider or by any skilled medical interpreter at the Provider's site; (e) Provider licensing information; (f) whether it is accessible for people with physical disabilities; (g) whether it is accepting new patients; (h) whether it is accessable by public transportation; and (h) any languages other than English spoken by Provider or by skilled medical interpreters at Provider's site, and whether translation services are available. [Section 2.14.5.2.1 of Three-Way Contract]

60. Upon MCO's request, Providers must provide the following information: (a) its name, address, and telephone number; (b) its training in and experience treating, including any expertise in treating persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness, individuals who are homeless, individuals who are deaf, hard-of-hearing, blind and/or visually impaired, persons with co-occurring disorders, and other specialties; (c) its office hours, including the name of any provider site open after 5:00 p.m. (Eastern Time) weekdays and/or open on weekends; (d) whether it has completed cultural competence training; (e) its licensing information; (f) whether it has specific accomodations for people with physical disabilities; (g) whether it is accepting new patients; (h) whether it is on a public-transportation route; (h) any languages other than English, including ASL, spoken by Provider or offered by skilled medical interpreters at Provider's site, and whether Provider has access to language line interpreters; (i) if Provider is a behavioral-health provider, its training in and experience treating trauma, child welfare, and substance abuse. [Section 2.14.5.2.1 of Three-Way Contract]

61. As requested and required, Provider must provide any information that CMS and/or MDHHS require (a) under the Three-Way Contract related to the performance of MCO's responsibilities, including non-medical information for the purposes of research and evaluation; (b) to comply with all applicable federal or state laws and regulations; and (c) for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Grievances and Appeals, and enrollment/disenrollment rates. [Section 2.16.1.1 of Three-Way Contract]

62. Collaborate with MCO in the collection and maintenance of all Encounter Data for all Covered Services that Provider provides to Enrollees, ensuring that all such data can be linked to MDHHS eligibility data. [Section 2.17.1.4 of Three-Way Contract]

63. In connection with the Demonstration, Provider shall act in an independent capacity and not as an officer or employee of the federal government, MDHHS, or their respective authorized agents. [Section 5.1.3.1 of Three-Way Contract]

64. Provider may not require any co-payments or other cost-sharing arrangements from Enrollees. Provider must not bill Enrollees for the difference between the Provider's charge and the MCO's payment for Covered Services. Provider must not seek or accept additional or supplemental payment from the Enrollee, his or her family, or representatives, in addition to the amount paid by the MCO even when the Enrollee signed an agreement to do so. [Section 5.1.9.4 of Three-Way Contract]

65. Provider shall not have any interest that will conflict, as determined by CMS and MDHHS with the performance MCO's services under the Three-Way Contract, or that may be otherwise anticompetitive, including without limitation any financial, legal, contractual, or other business interest

in any entity performing enrollment functions for MDHHS. [Section 5.3.17.1 of Three-Way Contract]

66. Provider shall conduct all activities in accordance with the Enrollee rights and protections set forth under 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and Appendix B ("Enrollee Rights") of the Three-Way Contract. [Appendix B of Three-Way Contract]

67. Provider may not reuse or provide other entities access to the CMS information system, or data obtained from the system or the State of Michigan, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the MCO contracted with CMS and the State of Michigan. [Appendix G of Three-Way Contract]

68. Provider shall cooperate with MCO with respect to MCO's obligations under the Three-Way Contract, including without limitation:

a. MCO's obligation to implement an evidence-based model of care for Members consistent with the requirements set forth in the Three-Way Contract. [Section 2.5.1.8.1 of Three-Way Contract]

b. MCO's obligation to assist the State in ensuring that HCBS Members' residential and nonresidential settings are in compliance with the requirements set forth in the HCBS Final Rule. [Section 2.7.2.3.1.1 of Three-Way Contract]

69. Provider acknowledges and agrees that MCO shall not pay for any item or service (other than an emergency item or service, not including items or services furnished in an emergency room or hospital): (a) furnished under the Three-Way Contract by any individual or entity during any period when that individual or entity is excluded from participation under Titles V, XVIII, XIX, or XX or Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act, or under regulations at 42 C.F.R. Part 1001 *et seq.*, or furnished by any individual or entity that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. § 1001.1801 and § 1001.1901; (b) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, XIX, or XX or Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); or (c) furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments. Provider furthermore acknowledges and agrees that MCO shall not pay for any item or service: (a) for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; or (b) furnished by a home health care services agency or organization, unless that agency or organization provides the State with a surety bond upon the implementation of Section 1861(o)(7) of the Social Security Act. [Section 2.7.3.5 of Three-Way Contract]

70. Provider shall not impose any cost-sharing amounts (including without limitation deductibles, coinsurance, or copayments) on Indian Enrollees served by an Indian Health Care Provider or through referral under contract health services. [Section 2.7.3.9.7 of Three-Way Contract]

Individual Sites Regulatory Compliance Addendum - Exhibit B-3

Florida Medicaid and Florida Healthy Kids Compliance Addendum - Subcontractor

Coventry Health Care of Florida, Inc., an Aetna Company (hereinafter "Company" or "Coventry") contracts with Florida Agency for Health Care Administration ("AHCA") and Florida Healthy Kids Corporation ("FHKC") (AHCA and FHKC are collectively referred to herein as "Agency") to provide Medicaid managed care and other public health services to beneficiaries (collectively referred to as the "State Contract").

This Florida Medicaid Compliance Addendum ("Addendum") is incorporated by reference into the Agreement. If there is any conflict between the terms of this Addendum and any 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 the terms of the Agreement, including this Addendum, and the State Contract, as amended, then the terms of the State Contract will govern and control.

For purposes of this Addendum, the term "Subcontractor" shall mean the individual or entity executing the Agreement, as identified on the first page of the Agreement, which may be a health care physician, provider, group, facility, hospital, an individual, entity or delegated entity.

This Addendum shall apply to services performed on behalf of Company's Florida Members. To the extent applicable to the services provided by Subcontractor pursuant to the Agreement, the following provisions apply:

I. **Records.** Subcontractor shall maintain books, records, and documents (including electronic storage media) pertinent to performance under the Agreement in accordance with generally accepted accounting procedures and practices, which sufficiently and properly reflect all revenues and expenditures of funds provided under the Agreement. Subcontractor shall make these records subject at all reasonable times to inspection, review, or audit by state personnel and other personnel duly authorized by the Agency, as well as by federal personnel.

Subcontractor shall maintain records relating to the Agreement for a period not less than ten (10) years from the close of the State Contract and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Company if the Agreement is continuous. [State Contract, Attachment II, Section VIII.B.3.b.(3)]

Subcontractor shall submit all reports and clinical information required by Company as applicable. [State Contract, Attachment II, Section VIII.B.3.c.(2)]

As applicable, Participant Direct Option ("PDO") records submitted by Subcontractor shall include at a minimum: services to be provided; hourly rate; Direct Service Worker work schedule; relationship of Direct Service Worker to enrollee; job description and duties; agreement statement; and dated signatures of case manager, enrollee and Direct Service Worker. [State Contract, Attachment II, Exhibit II-B, Section V.A.2.d.(5)]

II. Compliance. Subcontractor shall comply with:

A. The privacy and security provisions of the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164. [State Contract, Attachment II, Section VIII.B.3.d.(2)]

B. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin.

C. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap.

D. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex.

E. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age.

F. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.

G. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.

H. All regulations, guidelines, and standards as are now or may be lawfully adopted under the above statutes.

I. Section 274A(e) of the Immigration and Nationality Act and shall not knowingly employ unauthorized aliens. Subcontractor shall utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to the Agreement. Violation of this section shall be cause for unilateral cancellation of this Agreement by Company.

J. The False Claims Act, 31 USC § 3729, and all relevant whistleblower protections. [State Contract, Attachment II, Section VIII.B.3.d.(12)]

K. All state and federal marketing requirements, including 42 CFR 438.104 and Florida Statutes §§ 409.912, 641.3901, 641.3903, 641.386, 626.112, 626.342, 626.451, 626.471, 626.511, 626.611, 626.9541, and 626.9521. [State Contract, Attachment II, Section III.D.1.b]

L. All state and federal law governing the monitoring, interception, recording, use or disclosure of wire, oral, or electronic communications, including but not limited to the Florida Security of Communications Act, §§ 934.01 et. seq., Florida Statutes, and the Electronic Communications Privacy Act, 18 USC § 2510 et seq. (collectively "Communication Privacy Laws"). Prior to intercepting, recording, or monitoring any communications which are subject to Communication Privacy Laws, Subcontractor shall submit a plan to Company, which shall submit it for approval by the Agency. [State Contract, Attachment II, Section XII.L.1,2]

M. The applicable provisions of 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106 as related to sub contractual relationships and delegation, and disclosure of information on ownership, control, business transactions, and criminal convictions. [State Contract, Attachment II, Section VIII.B.1.b]

N. The State Contract prohibition on subcontractors seeking payment from Medicaid Pending enrollees on behalf of Company. [State Contract, Attachment II, Exhibit II-B, Section, Section III.A.4.f.]

O. All applicable federal and state Fiscal/Employer Agent ("F/EA") requirements and duties for PDO enrollees when such duties are subcontracted by Company. [State Contract, Attachment II, Exhibit II-B, Section V.A.2.e.(1), (2)].

P. The applicable provisions of Florida Statute § 415.1034 regarding the reporting of suspected cases of abuse, neglect and/or exploitation of elders and individuals with disabilities.to Company and the Florida Abuse Hotline. [State Contract, Attachment II, Exhibit II-B, Section, V.D.2.a].

Q. Voluntary, involuntary, and transport provisions of the Baker Act (see chapters 394, 400 and 429, F.S.) for Long-term Care residents with psychiatric issues. [State Contract, Attachment II, Exhibit II-B, Section V.D.7.k.]

R. The minimum Home and Community Based ("HCB") Settings Requirements for assisted living facilities ("ALF"), adult family care home ("AFCH") , and adult day health care ("ADHC") providers as applicable. [State Contract, Attachment II, Exhibit II-B, Section VI.C.1.b.(2)]

S. The Assisted Care Communities Resident Bill of Rights for ALF's as provided for under Florida Statutes § 429.28 if applicable. [State Contract, Attachment II, Exhibit II-B, Section VI.C.1.b.(2)]

T. All Provider Credentialing and Contracting requirements of the State Contract including, but not limited to Table 1 and Table 2 (State Contract, Attachment II, Exhibit II-B, Section VI.C.1.d.) and the specific prohibition against "direct services providers" with disqualifying offenses providing services to enrollees. [State Contract, Attachment II, Exhibit II-B, Section VI.C.1.a].

III. Oversight.

A. Company shall provide a mechanism for requiring corrective action, revoking delegation, or imposing other sanctions if Subcontractor's performance is inadequate. [State Contract, Attachment II, Section VIII.B.3.d.(10)]

B. The Agency and the U.S. Department of Health and Human Services may evaluate, through inspection of records pertinent to the State Contract or other means, the quality, appropriateness, and timeliness of services performed. [State Contract, Attachment II, Section VIII.B.3.b.(1)(2)]

C. Subcontractor shall provide full cooperation in any investigation by the Agency, Medicaid Provider Integrity, Medicaid Fraud Control Unit, Department of Elder Affairs, or other state or federal entity or any subsequent legal action that may result from such an investigation. [State Contract, Attachment II, Section VIII.B.3.d.(5)]

D. Subcontractor shall be subject to background checks at such level and scope determined by Company. . [State Contract, Attachment II, Section VIII.B.4.a. and Section II, D.28]

E. Upon request and as required by state and/or federal law, Subcontractor shall make available to all authorized federal and state oversight agencies and their agents, including but not limited to, the Agency, the Florida Attorney General, and Department of Financial Services any and all administrative, financial and medical/case records and data relating to the delivery of items or services for which Medicaid monies are expended. [State Contract, Attachment II, Section VIII.F.4.d.9.(a)]

F. Subcontractor shall allow access to all authorized federal and state oversight agencies and their agents, including but not limited to, the Agency, the Florida Attorney General, and Department of Financial Services to any place of business and all medical/case records and data, as required by state and/or federal law. Access shall be during normal business hours, except under special circumstances when the Agency, Florida Attorney General, and Department of Financial Services shall have after hours admission. The Agency and Florida Attorney General shall determine the need for special circumstances. [State Contract, Attachment II, Section VIII.F.4.d.9.(b)]

G. Subcontractor shall be eligible for participation in the Medicaid program; however, Subcontractor is not required to participate in the Medicaid program as a provider. [State Contract, Attachment II, Section VIII.B.2.a]

H. Subcontractor may not seek payment from a Medicaid pending enrollee on behalf of Company. [State Contract, Attachment II, Section VIII.B.3.a.(6)]

I. Subcontractor shall participate in applicable internal and external quality improvement, utilization review, peer review, and grievance procedures established by Company. [State Contract, Attachment II, Section VIII.B.3.c.(3)]

IV. **Amendment.** If the Agency determines, at any time, that the Agreement is not in compliance with the State Contract, Company may unilaterally amend the Agreement to bring it into compliance. [State Contract, Attachment II, Section VIII.B.1.a]

V. **Termination.** In addition to any other right to terminate in the Agreement or the State Contract, Company may request immediate termination of the Agreement, to the extent applicable to services provided by Subcontractor to Company under the State Contract, if Subcontractor fails to abide by the terms and conditions of the Agreement and fails to come into compliance, in Company's discretion, with the Agreement within fifteen (15) calendar days after receipt of notice from Company of Subcontractor's failure to abide by the terms of the Agreement. [State Contract, Attachment II, Section VI.C.6.c.(31)]

Miscellaneous. All executed subcontracts under the State Contract shall meet the following requirements:

A. Subcontractor shall not provide or assist in the completion of enrollment or disenrollment requests or restrict the enrollee's right to disenroll voluntarily in any way. [State Contract, Attachment II, Section II.D.8 and Section III, C.1.d]

B. If Subcontractor is conducting credentialing, Subcontractor shall conduct credentialing of providers in accordance with Company's and the Agency's credentialing requirements as found in the State Contract. [State Contract, Attachment II, Section VI.C.]

C. Subcontractor shall comply with Company's cultural competency plan. [State Contract, Attachment II, Section VI.C.6.c.(18)]

D. Subcontractors that meet the definition of "direct service provider" must complete abuse, neglect and exploitation training. [State Contract Attachment II, Section VI. C. 6. c. (10)]

E. A subcontracted direct service provider who has a disqualifying offense as set forth in s. 430.0402, F.S., and s. 435.04 F.S. is prohibited from providing services to enrollees. No additional Level II screening is required of the subcontracted provider if the provider is a Limited Enrolled or Fully Enrolled Medicaid provider. No additional Level II screening is required of an employee or volunteer of the subcontracted provider who is qualified for licensure or employment by the Agency pursuant to its background screening standards under s. 408.809 and the individual is providing a service that is within the scope of his or her licensed practice or employment. [State Contract Attachment II, Exhibit II-B, Section VI. C.1.a.]

F. Subcontracted providers shall screen enrollees for signs of domestic violence and shall offer referral services to applicable domestic violence prevention community agencies. [State Contract, Attachment II, Exhibit II-B, Section V.F.3.]

G. Subcontracted providers shall develop and maintain policies and procedures for back-up plans in the event of absent employees, and shall maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees. [State Contract Attachment II, Exhibit II-B, Section VI.C.2.a.(1)]

H. If the duty to collect enrollee's patient responsibility is transferred by Company to subcontracted residential provider, the subcontracted residential provider agrees to abide by the terms and conditions of the State Contract, Section X. [State Contract, Attachment II, Exhibit II-B, Section VI.C.2.a.(2)]

I. Subcontracted residential providers are prohibited from the assessment of late fees against enrollees. [State Contract, Attachment II, Exhibit II-B, Section X. D. 1].

J. If subcontracted provider is an ALF or an AFCH, it shall conform to the HCB characteristics pursuant to the State Contract. In addition, (insert ALF/AFCH Identifier) will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities. [State Contract, Attachment II, Exhibit II-B, Section VI.C.2.a.(3)].

Enrollees residing in (insert ALF/AFCH identifier) shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Private or semi-private rooms, as available;
- Roommate for semi-private rooms;
- Locking door to living unit;
- Access to telephone and unlimited length of use;
- Eating schedule;
- Activities schedule; and
- Participation in facility and community activities.

Ability to have:

- Unrestricted visitation; and
- Snacks as desired.

Ability to:

- Prepare snacks as desired; and
- Maintain personal sleeping schedule.

K. If subcontracted provider is an ALF it hereby agrees to accept monthly payments from (insert plan identifier) for enrollee services as full and final payment for all Long-term Care services detailed in the enrollee's plan of care which are to be provided by (insert ALF identifier). Enrollees remain responsible for the separate ALF room and board costs as detailed in their resident contract. As enrollees age in place and require more intense or additional Long-term Care services, (insert ALF identifier) may not request payment for new or additional services from an enrollee, their family members or personal representative. (Insert ALF identifier) may only negotiate payment terms for services pursuant to this provider contract with (insert plan identifier). [State Contract Attachment II, Exhibit II-B, Section VI.C.2.a.(4).]

L. If subcontracted provider is an ADHC provider, it shall conform to the HCB charateristics pursuant to the State Contract. In addition, (Insert ADHC provider identifier) will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities. [State Contract, Attachment II, Exhibit II-B, Section VI.C.2.a.(5).]

Enrollees accessing adult day health services in (insert ADCC identifier) shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Daily activities;
- Physical environment;
- With whom to interact;
- Access to telephone and unlimited length of use;
- Eating schedule;
- Activities schedule; and
- Participation in facility and community activities.

Ability to have:

- Right to privacy;
- Right to dignity and respect;
- Freedom from coercion and restraint; and
- Opportunities to express self through individual initiative, autonomy, and independence.

M. If subcontracted provider is a nursing facility or hospice, it shall maintain active Medicaid enrollment and submit required cost reports to the Agency for the duration of the Agreement. [State Contract, Attachment II, Exhibit II-B, Section VI.C.2.a.(6)]

N. The individual signing the Agreement has authority to do so. The Agreement includes all of the requirements of the State Contract. [State Contract, Attachment II, Section VI.C.6.c.(38)]

O. Subcontractor agrees that patients, AHCA, and Company shall not be held liable for any of Subcontractor's debts. This provision shall survive termination of the Agreement, including breach due to insolvency. [State Contract, Attachment II, Section VIII.B.3.d.(3)]

P. Subcontractor shall indemnify, defend, and hold the Agency, its designees and Company's enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause shall survive termination of the Agreement, including breach due to insolvency. The Agency may waive this requirement for itself, but not Company's enrollees, for damages in excess of the statutory cap on damages for public entities, if Subcontractor is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by the Agency. [State Contract, Attachment II, Section VIII.B.3.d.(6)]

Q. Subcontractor shall secure and maintain, during the life of the Agreement, workers' compensation insurance for all of its employees connected with the work under this the Agreement unless such employees are covered by the protection afforded by Company. Such insurance shall comply with the Florida Workers' Compensation Law. [State Contract, Attachment II, Section VIII.B.3.d.(7)]

R. If Subcontractor delegates or subcontracts any functions of the Agreement, the subcontract or delegation shall include all of the requirements of the Agreement. [State Contract, Attachment II, Section VIII.B.3.d.(8)]

S. Provisions of this Agreement that are in conflict with the specifications of the State Contract are waived. [State Contract, Attachment II, Section VIII.B.3.d.(9)]

T. If Subcontractor will conduct utilization management activities, Company and Subcontractor shall ensure that the Agreement does not structure compensation so as to provide incentives for Subcontractor to deny, limit, or discontinue medically necessary services to any enrollee. [State Contract, Attachment II, Section VIII.B.3.d.(11)]

U. Subcontracted Home and Community Based Service Providers ("HCBS") shall report critical incidents to Company within twenty-four (24) hours of the incident. Nursing facilities and assisted living facilities are not required to report critical incidents or provide incident reports to Company. Critical incidents occurring in nursing facilities and assisted living facilities will be addressed in accordance with Florida law, including but not limited to Florida Statutes §§. 400.147, 429.23, Chapter 39 and Chapter 415. [State Contract, Attachment II, Exhibit II-B, Section VI.F.1.b.]

Individual Sites Regulatory Compliance Addendum - Exhibit B-4

Regulatory Compliance Addendum Governing Kentucky Medicaid Services

This Regulatory Compliance Addendum Governing Kentucky Medicaid Services (the "Kentucky Medicaid Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under the *Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Coventry Health and Life Insurance Company* (the "State Contract"), under which contract Coventry Health and Life Insurance Company or its successor in interest (the "Company") serves as a managed-care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract.

The Commonwealth of Kentucky, its Finance and Administration Cabinet, its Cabinet for Health and Family Services, and/or its Department for Medicaid Services (collectively, the "State"), require that specific terms and conditions be incorporated into the Agreement. As such, this Kentucky Medicaid Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof), and such provider, vendor, contractor, or other entity must comply with the requirements set forth herein to the extent applicable to the services provided by vendor under the Agreement. Note that this Kentucky Medicaid Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in the policies, procedures, and provider manual of Company (or its Affiliate, as the case may be). This Kentucky Medicaid Addendum and the Agreement may be revised as directed by the State.

For purposes of this Kentucky Medicaid Addendum, the individuals who are enrolled with Company under the State Contract will be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Kentucky Medicaid Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Kentucky Medicaid Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Kentucky Medicaid Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contract and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract. Except as provided herein, all other provisions of the Agreement not inconsistent with this Kentucky Medicaid Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Kentucky Medicaid Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

To the extent applicable to the services provided by vendor under the Agreement, the provider, vendor, contractor, or other entity identified on the first page of the Agreement represent and warrant that it/they shall take all steps necessary

to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Kentucky Medicaid Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

E. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this Kentucky Medicaid Addendum:

a. "Medically Necessary" or "Medical Necessity" – Nothwithstanding any definition thereof set forth in the Agreement, the foregoing terms shall mean Covered Services that are medically necessary as defined under Section 2 of 907 KAR 3:130, and provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. § 1396d(r). [State Contract § 1.0]

b. "Provider" – Any person or entity under contract with Company or Company's contractual agent that provides Covered Services to Members. [State Contract § 1.0]

c. "Subcontract" – Any agreement entered into, directly or indirectly, by Company to provide or arrange for the provision of Covered Services. The term "Subcontract" does not include a policy of insurance or reinsurance purchased by Company or its Subcontractor to limit its specific or aggregate loss with respect to Covered Services provided to Members under the State Contract, so long as Company or its risk-assuming Subcontractor assumes some portion of the underwriting risk for providing health care services to Members. [State Contract § 1.0]

d. "Subcontractor" – Any entity other than a Provider, a physician health organization, or a provider network with which Company has entered into a written agreement for the purpose of fulfilling an obligation of Company under the State Contract. [State Contract § 1.0]

F. Requirements Applicable to Contracts and Services

1. Provision of Covered Services. Provider agrees to provide Covered Services to Members as set forth in the Agreement, including without limitation the following when such Covered Services are specified in the Agreement:

a. If a Member requires emergency medical services, Provider will provide such services on a twenty-four (24) hour per day, seven (7) day per week basis. Provider will provide urgent care services within 48 hours of request. [907 KAR 17:015, § 2; State Contract §§ 29.7, 33.3]

b. If a Member requires the services of a specialist, Provider will provide such specialty services within thirty (30) days from the referral for routine care or within forty-eight (48) hours from the referral for urgent care. [907 KAR 17:015, § 2; State Contract § 29.7]

c. Provider shall provide Covered Services to Members in accordance with the State Medicaid plan, applicable State regulations, and the relevant policies and procedures applicable to each category of Covered Services. [State Contract § 31.1]

d. Provider shall provide basic, targeted, or intensive case management services as Medically Necessary to foster children who are discharged from a hospital or other residential facility, and shall thereafter participate in appropriate discharge planning that is focused on ensuring that the needed supports and services to meet the Member's behavioral-health and physical-health needs will be provided outside of the hospital or other residential facility. [State Contract § 36.4]

e. If Provider is a PCP, Provider shall perform the PCP functions set forth in Section 28.3 of the State Contract. [State Contract § 28.3]

f. Company shall not require Provider to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. § 438.102. Instead, Company shall have a referral process for situations in which a Provider declines to perform a service for ethical reasons. [State Contract § 28.12]

2. Claims; Payment; Coordination of Benefits.

a. Company shall only accept from Provider the uniform claim forms that have been approved by the State and that have been completed according to State guidelines. Provider acknowledges and agrees that the date of Company's receipt of any Provider claim shall be the date as indicated on its date stamp on the claim or other notation as appropriate to the medium used to file a claim, and that the date of payment shall be the date of the check or other form of payment. [State Contract §§ 30.1. 30.2]

b. Provider acknowledges and agrees that with respect to any Covered Services provided to Dual Eligible Members (as that term is defined in the State Contract), Company shall pay to Provider the lesser amount of: (1) Company's allowed amount minus the Medicare payment, or (2) the Medicare co-insurance and deductible up to Company's allowed amount. [State Contract § 30.4]

c. Provider/Subcontractor acknowledges and agrees that with respect to any Covered Services, Company shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) that is: (1) furnished by any individual or entity during any period when that individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act; (2) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); (3) furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments; (4) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (5) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Medicaid plan; or (6) for home health care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in section 1861(o)(7) of the Social Security Act. [State Contract § 3.7(A)]

d. Upon request of Provider, Company shall provide or make available to Provider, when contracting or renewing this Agreement with such Provider, the payment or fee schedule or other information sufficient to enable Provider to determine the manner and amount of payments under the Agreement for Provider's services prior to the final execution or renewal of the Agreement, and shall provide any change in such schedules at least ninety (90) days prior to the effective date of any such amendment; provided, however, that Company may make periodic, non-material changes to its payment or fee schedules, such as updates to standard codes and guidelines developed by the American Medical Association or a similar organization, or such as changes required by the State or CMS, without prior written notice. [KRS 304.17A-527(1)(d); KRS 304.17A-577(1)(a); KRS 304.17A-577(2)]

e. In no event shall the State or any Member be liable for the payment of any debt or fulfillment of any obligation of Company, Provider/Subcontractor, or any subcontractor to any Provider/Subcontractor, supplier, out-of-network provider, or any other party, for any reason whatsoever, including the insolvency of Company or any Provider/Subcontractor. Provider/Subcontractor agrees that any contracts that Provider/Subcontractor has with its subcontractors will contain a hold harmless provision and will comply with all provisions of the Agreement. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527; State Contract § 13.2]

f. Provider/Subcontractor shall not directly receive payment or any type of compensation from Members for providing Covered Services. Provider/Subcontractor may not bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or any persons acting on their behalf, for services rendered in accordance with the Agreement. This prohibition applies even if Company becomes insolvent, fails to pay Provider/Subcontractor for services rendered, or otherwise breaches the Agreement. This provision does not prohibit the collection from Members of State-authorized co-pays, co-insurance, or deductibles for providing Covered Services. Member co-pay, co-insurance, or deductible amounts cannot exceed the amounts specified in 907 KAR 1:604. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527; State Contract §§ 11.8, 14.2, and 31.4]

g. Provider/Subcontractor shall not bill a Member for Medically Necessary Covered Services, with the exception of applicable co-pays or other cost sharing requirements provided under the State Contract. If Provider/Subcontractor knowingly and willfully bills a Member for a Medicaid Covered Service, Provider/Subcontractor shall be guilty of a felony and upon conviction may be fined 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 Company becomes insolvent. If a Member agrees, in advance, to pay for a service that is not a Covered Service under the State Contract, Company or Provider/Subcontractor may bill the Member for that service. The standard release form signed by a Member at the time of services does not relieve Company or Provider/Subcontractor from the prohibition against billing a Member in the absence of a knowing assumption of liability for a non-Covered Service. The form or other type of acknowledgement relevant to the Member's liability for non-Covered Services shall specifically state the services or procedures that are not covered by Medicaid. [State Contract § 31.4]

h. If Provider/Subcontractor is involved in coordination-of-benefits collections, Provider/Subcontractor shall report coordination-of-benefits information to Company. Provider/Subcontractor shall not pursue collection from the Member, but rather must pursue collection directly from the third party payer or the provider. Access to Covered Services shall not be restricted due to coordination-of-benefits collection. The State has the right to review all billing histories and other data related to coordination-of-benefits activities for Members. [State Contract § 14.1]

i. Company shall process all health care claims submitted for the provision of Covered Services to Members in accordance with KRS 304.17A-726. [KRS 304.17A-726]

j. Provider/Subcontractor acknowledges and agrees that Company shall not pay a Provider/Subcontractor for any provider-preventable condition that meets the following criteria: (1) is identified in the State Medicaid plan; (2) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (3) has a negative consequence for the Member; (4) is auditable; and (5) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. Provider/Subcontractor shall report all provider-preventable conditions associated with claims for payment or Member treatments for which payment would otherwise be made. [State Contract § 31.7]

k. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state plan or waiver.

l. Company shall not be liable to make any payments for Covered Services for which Provider/Subcontractor fails to follow the preadmission authorization and eligibility verification (for inpatient or outpatient services) procedures set forth in the Agreement, the State Contract, or the Medicaid program. Furthermore, all or a portion of payment due to the Provider/Subcontractor may be denied by Company if such payment is specifically attributable to Provider/Subcontractor's rendering or ordering: (i) services that are not Medically Necessary; (ii) elective hospitalization not authorized by Company; (iii) services provided other than at an authorized level of care; (iv) services that are not Covered Services; or (v) services related to complications from a non-Covered Service. In the event Provider/Subcontractor does not agree with a denial of payment determination made, Provider/Subcontractor may file an appeal in accordance with applicable procedures. [State Contract § 28.9]

3. Any Willing Provider; Provider Application; No Discrimination. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall comply with the "any willing provider" statute as described in 907 KAR 1:672 and KRS 304.17A-270, as amended. Neither Company nor such Subcontractor shall require a Provider to enroll exclusively with its network to provide Covered Services under the State Contract. Nothing in the Agreement shall require or be construed to require a Provider, as a condition of participation in the Medicaid product that is the subject of the State Contract, to participate in any other products offered by Company. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall comply with the terms and obligations set forth in KRS 304.17A-525, and shall allow all providers who desire to apply for network participation an opportunity to apply at any time during the year or, where Company or such Subcontractor does not conduct open continuous provider enrollment, shall conduct a provider-enrollment period at least annually with the date publicized to providers located in the geographic service area of the plan at least thirty (30) days in advance of such enrollment period. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall not discriminate against providers that serve high-risk populations or that specialize in conditions that require costly treatment, and shall not discriminate against a provider based upon that provider's licensure or certification. If Company or such Subcontractor declines to include a provider within its network, it shall give that affected provider written notice of the reason for its decision. Any option to terminate this Agreement without cause, or to non-renew this Agreement, that Company possesses under the terms thereof shall be subject to the "any willing provider" statute and to Provider's right to reapply for network participation, and Company will consider any such Provider reapplication consistent with the internal standards, policies, and procedures for provider participation that Company has developed in accordance with KRS 304.17A-270 and KRS 304.17A-525. [KRS 304.17A-150; KRS 304.17A-270; KRS 304.17A-525; State Contract § 29.1]

4. Anti-Gag Clause; No Retaliation. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall not limit a Provider's disclosure to a Member, or to another person on the Member's behalf, of any information relating to the Member's medical condition, health status, medical care, or treatment options (regardless of whether benefits for such care are provided under the State Contract), and shall not prohibit Provider from discussing all treatment options with the Member. Provider shall not be penalized, and no agreement with a Provider may be terminated, because Provider discusses Medically Necessary or clinically appropriate care with a Member or another person on the Member's behalf. Other information determined by Provider to be in the Member's best interest may be disclosed by Provider to Member or to another person on Member's behalf. Provider shall not be penalized for discussing with a Member any financial incentives and arrangements between the Provider and Company/Subcontractor, nor shall Company take any punitive action against a Provider that either supports, or requests an expedited resolution of, a Member's appeal. [KRS 304.17A-530; State Contract §§ 28.1, 28.12, 31.1]

5. Provider Grievances. Provider shall submit any grievance against Company on the State-approved provider grievance form. [State Contract § 28.9]

6. Connectivity to KHIE. If Provider is a PCP, Provider shall establish connectivity to the Kentucky Health Information Exchange ("KHIE") within one year of the effective date of this Agreement, or as otherwise

determined by the State. If Provider is not a PCP, Company still encourages Provider to establish connectivity to KHIE. [State Contract § 17]

7. HEDIS and Encounter Data. Provider/Subcontractor shall submit all reports and clinical information required by Company, including but not limited to, HEDIS, EPSDT, etc., in such manner and pursuant to such timeframes requested by Company. Notwithstanding anything herein to the contrary, Provider/Subcontractor shall provide all necessary data, including but not limited to encounter and claims data, to Company in a format specified by the State in accordance with 42 C.F.R. § 438, unless otherwise agreed by the parties. Provider/Subcontractor shall report and/or submit all encounter records in an accurate and timely fashion. [State Contract §§ 16.1, 20.2, 33.1]

8. Amendments; Notice of Material Change. Company may unilaterally amend the Agreement to the extent necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards, or licensing guidelines or rules ("Regulatory Amendment"). Company shall give advance written notice to Provider of such Regulatory Amendment and the effective date thereof. With respect to amendments other than Regulatory Amendments, Company shall give advance written notice to any "participating provider" of any "material change" to this Agreement, as those terms are used and defined in KRS 304.17A-578, at least ninety (90) days prior to the effective date of the amendment. If Provider is a "participating provider" as that term is used and defined in KRS 304.17A-578: (i) the material-change notice shall include a description of the material change and a statement that Provider has the option to withdraw from the Agreement prior to the material change becoming effective; and (ii) Provider shall send written notice no later than forty-five (45) days prior to the effective date of the material change if Provider opts to withdraw following notice of a material change; provided, however, if Company has not received notice of such withdrawal within that forty-five (45) day period, Provider's silence shall constitute acceptance of such amendment. If any change to the Agreement is with respect to an existing prior authorization, precertification, notification, or referral program, or changes to an edit program or specific edits, Company shall provide notice of the change to Provider at least fifteen (15) days prior to the change. [KRS 304.17A-578]

9. Assignment. The Agreement, being intended to secure the services of and be personal to Provider/Subcontractor, shall not be assigned or transferred by Provider/Subcontractor without the prior written consent of Company. Company may assign this Agreement without the consent of Provider/Subcontractor to any Affiliate or any other entity upon thirty (30) days' prior written notice. [State Contract § 6.2(H)]

10. Provider Subcontracts. If otherwise permissible under the Agreement, if Provider enters into a subcontract agreement with another provider to provide its licensed health care services to Members where the subcontracted provider will bill Company or Members directly for the subcontracted services, the subcontract agreement must meet all requirements of Ky. Rev. Stat. Chapter 304.17A and shall be filed with the Commissioner of the Kentucky Department of Insurance in accordance with Ky. Rev. Stat. § 304.17A-527(1)(e). [KRS 304.17A-527(1)(e)]

11. State Contract Creates No Third-Party Rights. Provider/Subcontractor acknowledges that the State Contract does not, and is not intended to, create any rights, benefits, or interests to Provider/Subcontractor. [State Contract § 4.5]

12. Subcontracts. With respect to any and all Subcontracts:

a. Subcontractor shall indemnify, defend, and hold harmless the State, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with the State Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor. [State Contract § 6.1]

b. Subcontractor, in the performance of its obligations, shall use only Medicaid-enrolled providers in accordance with the Agreement and the State Contract. [State Contract § 6.2(D)]

c. Subcontractor is prohibited from receiving any incentive, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services. In addition, a Subcontractor that performs utilization management activities is prohibited from receiving, and from providing to any individual or entity that performs such utilization management activities, any incentives for the denial, limit, or discontinuance of Medically Necessary Covered Services to a Member, all consistent with 42 C.F.R. §§ 422.208 and 438.6(h). [State Contract §§ 6.2(G), 21.2, 29.7]

d. Subcontractor is prohibited from assigning the Agreement or from further subcontracting without the prior written consent of the State. [State Contract § 6.2(H)]

e. The State is the intended third-party beneficiary of this Agreement and, as such, the State is entitled to all remedies that are afforded to third-party beneficiaries under the law. [State Contract § 6.2(I)]

f. Subcontractor, as required, shall timely submit encounter records in the format specified by the State so the Company can meet the specifications required by the State Contract. Subcontractor shall be responsible for transmitting all data to Company as required by 42 C.F.R. § 438. [State Contract §§ 6.2(J), 15.1]

g. Subcontractor shall comply with all provisions of the State Contract that relate to the services or activities that Company has delegated to Subcontractor under the Agreement, and Subcontractor shall furthermore comply with all applicable federal and State law and regulations, including but not limited to KRS 205.8451 through KRS 205.8483, all rules, policies, and procedures of the State, and all standards governing the provision of Covered Services and information to Members, all Quality Assessment/Performance Improvement (QAPI) requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of the State, the Office of Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and State agents to inspect, investigate, monitor, and audit operations, all indemnification and insurance requirements, and all obligations upon termination. [State Contract § 6.2(K)]

h. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor, on an ongoing basis, Subcontractor's performance and accreditation. Subcontractor shall be subjected to formal review by Company. [State Contract §§ 4.3(C), 6.2(L)]

i. Any Subcontractor with NCQA/URAC or other national accreditation shall provide Company with a copy of its current certificate of accreditation, along with a copy of the survey report. [State Contract § 6.2(M)]

j. Subcontractor shall report suspected fraud and abuse to Company. [State Contract § 6.2(P)]

k. If Company delegates to Subcontractor any activities or obligations of Company under the State Contract, Company may revoke such delegation or impose other sanctions if the Subcontractor's performance is inadequate, all in accordance with the terms set forth in the Agreement. [State Contract § 4.3(A)]

l. If Company identifies deficiencies or areas for improvement in the Subcontractor's performance under the Agreement, Subcontractor shall cooperate with Company in taking all necessary corrective action. [State Contract §§ 4.3(D), 6.2(N)]

m. If Company delegates to Subcontractor the selection of Providers under the Agreement, Company shall retain the right to approve, suspend, or terminate any Provider selected by that Subcontractor. [State Contract § 4.3(E)]

n. Subcontractor shall at all times remain in compliance with the requirements of 42 C.F.R. § 438. [State Contract § 4.3(F)]

o. A Subcontractor that provides Covered Services shall inform Company if that Subcontractor itself engages a subcontractor in any transaction or series of transactions, in performance of any term of the State Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense. [State Contract § 6.3]

p. Subcontractor acknowledges that the State shall have the right to invoke against Subcontractor any remedy that is set forth in the State Contract, including the right to require the termination of any Subcontract, for each and every reason for which the State may invoke such a remedy against Company or for which the State may require the termination of the State Contract. [State Contract § 6.4]

q. If Company delegates to Subcontractor any utilization-management activities or obligations, Subcontractor shall ensure that all utilization-management programs, processes, and timeframes are in accordance with 42 C.F.R. §§ 431, 438, and 456, with the private-review agent requirements of Ky. Rev. Stat. Chapter 304.17A, and with the State Contract. Such Subcontractor shall adopt Interqual or Milliman for Medical Necessity, except in the event that Interqual or Milliman is not applicable to the specific service being provided, in which case Subcontractor may use other appropriate criteria so long as (1) that criteria or standard is a nationally recognized standard of which the State Department for Medicaid Services has received prior notice, and (2) Subcontractor has confirmed that Interqual or Milliman do not, in fact, contain standards applicable to the specific service being provided. With respect to behavioral-health Medical Necessity determinations, Subcontractor shall adopt the following standardized tools: for adults, Level of Care Utilization System (LOCUS); for children, Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children, Early Childhood Service Intensity Instrument (ECSII); and for substance use, American Society of Addiction Medicine (ASAM). [State Contract § 21.2]

r. If Company delegates to Subcontractor any credentialing or recredentialing activities/obligations, Subcontractor shall conduct all such activities/obligations in compliance with National Committee for Quality Assurance (NCQA) standards, with 907 KAR 1:672, with applicable federal law, and with the State Contract. [State Contract § 28.2]

s. Subcontractor acknowledges (1) that neither it nor its agents, officers, or employees shall be construed to be officers or employees of the State by virtue of the Agreement or the State Contract, and (2) that neither the Agreement nor the State Contract shall be construed as a partnership or joint venture between Subcontractor and the State. [State Contract § 41.7]

t. Subcontractor acknowledges that it is aware of the requirements and penalties outlined in KRS 45A.485, has properly disclosed all information required by this statute, and will continue to comply with such requirements for the duration of the State Contract. [KRS 45A.485]

u. Subcontractor acknowledges that it is aware of the requirements of Executive Order 2015-370 (Minimum Wage for State Employees and the Commonwealth's Service Providers) and that it will pay all workers working on or in connection with the State Contract a minimum of $10.10 per hour for all regular, hourly employees and a minimum of $4.90 per hour for all tipped employees for the duration of the State Contract. [Executive Order 2015-370]

13. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy-related Covered Services:

a. Provider/Subcontractor shall administer all pharmacy benefits in accordance with the provisions and requirements of Section 32.1 of the State Contract and in accordance with all applicable State and federal laws and regulations. [State Contract § 32.1]

b. If Company delegates to Provider/Subcontractor any pharmacy-related activities or obligations under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 32.0 of the State Contract. [State Contract §§ 32.0–32.11]

c. Provider/Subcontractor shall cooperate with Company with respect to Company's obligation to process, adjudicate, and pay pharmacy claims in accordance with Section 32.4 of the State Contract, and to submit National Drug Code (NDC) level information on drugs and diabetic supplies, including J-code conversions consistent with CMS requirements. [State Contract §§ 32.4, 32.5]

d. Provider/Subcontractor shall comply with the pharmacy prior-authorization provisions and requirements set forth in Section 32.6 of the State Contract. [State Contract § 32.6]

e. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract to (1) establish and maintain a generic-drug Maximum Allowance Cost (MAC) program, and (2) manage specialty pharmacy drugs. [State Contract §§ 32.7, 32.8]

14. Behavioral-Health Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to behavioral-health Covered Services:

a. Provider/Subcontractor shall administer all behavioral-health benefits in accordance with the provisions and requirements of Section 34.3 of the State Contract and in accordance with all applicable State and federal laws and regulations. [State Contract § 34.3]

b. If Company delegates to Provider/Subcontractor any behavioral-health-related activities or obligations under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 34.0 of the State Contract. [State Contract §§ 34.0–34.12]

c. Providers shall document DSM-V diagnosis and assessment/outcome information in the Member's medical record. [State Contract § 34.3]

d. If Provider is a PCP, Provider shall have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavior-health problems and disorders. PCPs may provide any clinically appropriate behavior-health services within the scope of their practice. [State Contract § 34.7]

e. Provider shall provide behavioral-health services (1) within twenty-four (24) hours of the referral if that service requires crisis stabilization, and (2) within forty-eight (48) hours of the referral if that service is for behavioral-health urgent care. A behavioral-health service appointment following a discharge from an acute psychiatric hospital shall occur within seven (7) days of discharge, and any behavioral-health service appointment not otherwise specified in this subparagraph shall occur within sixty (60) days of the referral. [907 KAR 17:015, § 2; State Contract § 34.8]

f. Provider that is providing behavioral-health services (1) shall refer a Member with known or suspected and untreated physical-health problems to the Member's PCP for examination and treatment with the consent of the Member or the Member's legal guardian; (2) may only provide physical-health services if it is licensed to do so; (3) shall send initial and quarterly (or more frequently if clinically indicated) summary reports of the Member's behavioral-health status to the PCP with the consent of the Member or the Member's legal guardian; and (4) shall ensure that all Members receiving inpatient behavioral-health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge, with Provider ensuring that such outpatient treatment occurs within seven (7) days from the date of discharge and with Provider contacting Members who have missed an appointment within twenty-four (24) hours to reschedule that appointment. [State Contract §§ 34.7, 34.8]

g. A Provider that is providing behavioral-health services: (1) shall ensure continuity of care for successful transition of Members back into community-based supports; (2) shall participate in quarterly continuity-of-care meetings hosted by State-operated or State-contracted psychiatric hospitals; (3) shall assign a case manager prior to or on the date of discharge and provide basic, targeted, or intensive case management services as Medically Necessary to Members with severe mental illness ("SMI") and co-occuring developmental disabilities who are discharged from a State-operated or State-contracted psychiatric facility for Members with SMI; (4) shall participate in discharge planning meetings to ensure compliance with federal *Olmstead* and other applicable laws, with discharge planning 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; (5) shall thereafter ensure the community supports are meeting the needs of the Member discharged from a State-operated or State-contracted psychiatric hospital; and (6) shall assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs. [State Contract § 34.10]

15. Access to Premises. Subcontractor shall allow duly authorized agents or representatives of the State or federal government or the independent external quality-review organization required by Section 1902(a)(30)(c) of the Social Security Act, 42 U.S.C. § 1396a(a)(30), access to Subcontractor's premises during normal business hours to inspect, audit, investigate, monitor, or otherwise evaluate Subcontractor's performance. If such access to Subcontractor is requested, Subcontractor shall provide and make staff available to assist in the audit or inspection effort, and shall provide adequate space on its premises to reasonably accommodate the State, federal, or external quality-review personnel conducting the audit, investigation, or inspection effort. In addition, Subcontractor shall produce all records, documents, or other data requested as part of such review, investigation, or audit. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Subcontractor's activities. [State Contract § 5.6]

16. Physician Incentive Plan Requirements. In the event compensation to Provider under the Agreement includes Physician Incentive Plans as defined by federal law, those Physician Incentive Plans shall comply with 42 C.F.R. §§ 417.479, 422.208, 422.210, and 438.6(h). Company shall make no specific payment directly or indirectly under a Physician Incentive Plan to Provider as an inducement to reduce or limit Medically Necessary Covered Services furnished to a Member. The Physician Incentive Plans shall not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. Company shall disclose to CMS information on Physician Incentive Plans in accordance with 42 C.F.R. §§ 417.479(h)(1) and 417.479(l) and at the times indicated in 42 C.F.R. § 417.479(d)–(g). Provider further acknowledges and agrees that in the event Provider is deemed to be at substantial financial risk under applicable Physician Incentive Plan regulations, Provider shall (i) cooperate and assist Company in conducting satisfaction surveys of Members using the Provider's services, and (ii) obtain, at Provider's sole expense, any additional stop loss insurance required pursuant to the Physician Incentive Plan regulations. In the event Provider must obtain stop loss insurance pursuant to the Physician Incentive Plan regulations, Provider shall obtain a stop loss policy with the following terms: (i) the policy is guaranteed renewable; (ii) termination of the policy shall not affect or reduce the policy insurer's obligation to cover, or responsibility for coverage of, the Provider's claims for Covered Services provided to Members during the term of such policy and which are covered under the applicable Plan; and (iii) the policy insurer will provide notice of termination or cancellation of the policy to Company. Bonus amounts paid pursuant to the Agreement, if any, shall not exceed 33% of the maximum payments possible to Provider for services that Provider furnishes directly to Members. [State Contract §§ 11.6, 11.7]

17. Stop-Loss Coverage. If Provider assumes substantial financial risk for contracted services, Provider shall maintain adequate stop-loss protection, sufficient proof of which, including the amount and type of stop-loss coverage maintained, shall be provided to Company by Provider upon request. [State Contract § 13.5]

18. Quality Assessment/Performance Improvement (QAPI) Program. Provider/Subcontractor shall participate in Company's Quality Assessment/Performance Improvement program activities (including but not limited to submission of complete encounter records), shall cooperate with Company with respect to Company's QAPI

obligations under the State Contract, and shall cooperate with Company's Quality Improvement Committee. [907 KAR 17:025, § 6; State Contract §§ 19.1–19.4, 38.5]

19. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Provider/Subcontractor shall provide (and if Company delegates to Subcontractor the selection of Providers under the Agreement, Subcontractor shall ensure that its contracted Providers provide) EPSDT services to Members in compliance with the State Contract (and in particular Section 33.1 thereof), with 907 KAR 1:034, and with any policy statements issued by the State or CMS during the term thereof. Provider/Subcontractor shall also cooperate with Company with respect to Company's obligations under the State Contract to submit EPSDT reports to the State. [State Contract §§ 33.1, 38.9]

20. Third Party Liability. Provider/Subcontractor acknowledges and agrees that Medicaid payment, under the State Contract or otherwise, is secondary to other sources of payment for Covered Services provided to Members, and that Medicaid (and consequently Company, as a Medicaid MCO of the State) is the payer of last resort. Provider/Subcontractor furthermore acknowledges and agrees that when Company is aware of third-party sources of payment for Covered Services, Company is required by the State Contract to "cost avoid" (*i.e.*, deny) the associated claim and to redirect Provider/Subcontractor to bill that third-party source of payment as the primary payor. [State Contract § 14.2]

21. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to assist the State with its planning process for the State's CMS/CMMI State Innovative Model Design Award initiative, which involves the State partnering with health-system stakeholders to develop a State Healthcare Innovation Plan (SHIP). [State Contract § 5.7]

b. Company's obligation to notify the State of the existence and nature of any capitation agreement that Company has with Provider/Subcontractor pursuant to which Provider/Subcontractor assumes risk, including without limitation information relating to how Provider/Subcontractor pays its downstream providers/subcontractors for providing Covered Services to Members. [State Contract § 6.5]

c. Company's obligation to cooperate with the State as part of any readiness review under the State Contract. [State Contract § 8.1]

d. Company's obligation to submit financial and expense-related reports/data to the State relating to the Risk Corridor Payment Adjustment and the Medical Loss Ratio Adjustment set forth in the State Contract. [State Contract §§ 11.4, 11.5]

e. Company's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [State Contract §§ 14.1, 14.2, 38.4]

f. Company's obligation to assist the State with verification that Providers are meeting the requirements of the Electronic Health Records Incentive Payment Program. [State Contract § 18.0]

g. Company's obligation to submit HEDIS reports/data to the State as set forth in the State Contract. [State Contract §§ 20.1–20.3]

h. Company's obligation to develop and implement Performance Improvement Projects as set forth in the State Contract. [State Contract § 20.5]

i. Company's obligation to provide orientation, education, and training for Providers as set forth in the State Contract. [State Contract § 28.5]

j. Company's obligation to reduce unnecessary emergency room visits so that the determination of non-emergent visits is reduced to no more than two (2%) percent in a rolling three (3) month period for that particular Medicaid region in the State. [State Contract § 29.7(J)]

k. Company's obligation to submit to the State claims-level cost data for payment-verification purposes relating to the State's supplemental payments, if any, under Section 30.11 of the State Contract. [State Contract § 30.11]

l. Company's obligation to conduct health risk assessments (HRAs) of Members as set forth in the State Contract. [State Contract § 35.1]

m. Company's obligation to perform care coordination and develop care plans for Members as set forth in the State Contract. [State Contract § 35.3]

n. Company's obligation to assist the State with its development of health homes for Company's medically complex Members. Once approved by CMS, Provider/Subcontractor shall comply with any health home program developed by the State. [State Contract § 35.4]

o. Company's obligation to coordinate with the Women, Infants and Children (WIC) program, including provision of medical information to the WIC program by Providers if requested by WIC agencies and if permitted by applicable law. [State Contract § 35.5]

p. Company's obligation to participate in transition planning and continued care coordination for Members with SMI who are transitioning from licensed personal-care homes, psychiatric hospitals, or other institutional settings to integrated, community-based housing, including the performance of a comprehensive physical and behavioral-health assessment designed to support the successful transition to community-based housing within fourteen (14) days of the transition. [State Contract § 36.6]

q. Company's obligation to respond to any letter of concern, written deficiency notice, or request for a corrective action plan that Company receives from the State relating to Subcontractor or the services that are within the scope of the Agreement. [State Contract § 40.4]

22. Hospitalists. Nothing in the Agreement shall require, or be construed to require, the mandatory use of a hospitalist (defined as a physician of record at a hospital for a patient of a participating physician and who may return the care of the patient to that physician at the end of the hospitalization). [KRS 304.17A-532]

23. Licensing/Certification. Provider/Subcontractor shall meet all appropriate licensing and contract requirements specified in applicable State and federal laws and regulations. This includes certification, where required, to provide those health care services in the State as set forth in the Agreement, including certification under CLIA, if applicable. Where applicable, Provider/Subcontractor shall have a valid Drug Enforcement Agency registration number and valid NPI and taxonomy. [State Contract § 3.5]

24. Notice of Legal Action. Subcontractor shall provide written notice to Company of any legal action or notice listed below, within ten (10) days following the date Subcontractor receives written notice of:

a. Any action, proposed action, lawsuit, or counterclaim filed against Subcontractor related in any way to the Agreement or the State Contract;

b. Any administrative or regulatory action, or proposed action, respecting the business or operations of Subcontractor related in any way to the Agreement or the State Contract;

c. Any notice received by Subcontractor from the Kentucky Department of Insurance or the Kentucky Cabinet for Health and Family Services;

d. Any claim made against Subcontractor by a Member having the potential to result in litigation related in any way to the Agreement or the State Contract;

e. The filing of a petition in bankruptcy by or against Subcontractor, or the insolvency of Subcontractor; and

f. The payment of a civil fine or conviction of any person who has an ownership or controlling interest in Subcontractor, or who is an agent or managing employee of Subcontractor, of a criminal offense related to that person's involvement in a program under Medicare, Medicaid, or Title XX of the Social Security Act, or of fraud, or unlawful manufacture, distribution, prescription, or dispensing of a controlled substance, as specified in 42 U.S.C. § 1320a-7.

[State Contract 41.4]

25. Termination of Agreement and Effect Thereof. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the Parties. Furthermore, in the event this Kentucky Medicaid Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or Product Participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties. In addition:

a. In the event of a breach of the Agreement by Company, the termination of the Agreement, or the insolvency of Company, Provider/Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Agreement for the remainder of any month for which the State has made payments to Company, and shall fulfill all of its obligations respecting the transfer of Members to other Providers/Subcontractors, including record maintenance, access, and reporting requirements, all such covenants, agreements, and obligations of which shall survive the termination of the State Contract and the Agreement. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527(1)(c); State Contract §§ 6.1, 40.8]

b. In the event of termination for any reason other than a quality of care issue or fraud, Company shall continue to reimburse Provider/Subcontractor in accordance with the Agreement until the Member is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater; and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement is terminated. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527(1)(b)–(c); State Contract § 40.8]

c. Company and/or Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall terminate from participation any Provider that (i) engaged in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked, or suspended; (iii) has medical staff privileges at any hospital terminated, revoked, or suspended; or (iv) engaged in behavior that is a danger to the health, safety, or welfare of Members. Company and such Subcontractor may also terminate the participation of any Provider that has materially breached the Agreement and has failed to timely and adequately cure such breach. [State Contract § 29.6]

26. Protected Health Information. Provider/Subcontractor shall abide by the same statutes and regulations regarding the confidentiality of protected health information that Company is itself subject to under the State Contract and state and federal law, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d) and 45 CFR Parts 160 and 164. Company shall conduct HIPAA privacy and security audits of Provider/Subcontractor as prescribed by the State. This confidentiality provision shall survive termination of the Agreement. [State Contract § 39.1, 39.2, 41.15]

27. Access to Records. Provider/Subcontractor shall make all of its books, documents, papers, records, medical records, data, surveys, computer databases, or other evidence (collectively, the "Records") available for examination, audit, and/or program review by the State, the Finance and Administration Cabinet, the Auditor of Public Accounts, the Legislative Research Commission, the Attorney General of the State, the Kentucky Department of Insurance, the U.S. Department of Health and Human Services, CMS, the Office of Inspector General Comptroller, authorized federal or State personnel, and the authorized representatives of the governments of the United States and the State including, without limitation, any employee, agent, or subcontractor of the State, CMS, or the State's fiscal agent, for a period of five (5) years after termination of the State Contract, except when an audit has been conducted or audit findings are unresolved. In such case, Records shall be kept for a period of five (5) years in accordance with 907 KAR 1:672, or as amended or until all audit issues are finally resolved, whichever is later. Access shall be at the discretion of the requesting authority and shall be either through onsite review of Records or by submission of Records to the office of the requesting authority. Any Records requested shall be produced immediately for onsite reviews or sent to the requesting authority by mail within fourteen (14) days following a request. All Records shall be provided at the sole cost and expense of Provider/Subcontractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping, and/or mailing of records. The State shall have unlimited rights to use, disclose, and duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by Provider/Subcontractor. [State Contract §§ 38.2, 39.1, 41.17, 41.21]

28. Medical Records. With respect to medical records:

a. In addition to the requirements set forth in the Agreement, Provider/Subcontractor shall maintain Member medical records on paper or in an electronic format. Provider/Subcontractor shall maintain Member medical records in a timely, legible, current, detailed, and organized manner 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 State Contract. Medical records shall be signed by the Provider/Subcontractor, as the case may be. [907 KAR 17:015, § 12; State Contract § 28.7]

b. Although the medical records are the property of the Provider/Subcontractor that generates the record, each Member or the Member's representative is entitled to one (1) free copy of his/her medical record. Additional copies shall be made available at cost. Provider/Subcontractor shall preserve and maintain Member medical records for no less than five (5) years unless federal requirements mandate a longer retention period (*i.e.*, immunization and tuberculosis records shall be maintained for a Member's lifetime). [907 KAR 17:015, § 12; State Contract § 28.7]

c. Provider/Subcontractor's medical records shall meet the medical record standards that Company and the State Contract require for medical-chart organization and documentation, for the contents of the medical record, and for individual clinical-encounter documentation. Medical records will reflect all aspects of patient care, including ancillary services. Additionally, a PCP's primary medical record for each Member must contain sufficient medical information from all providers involved in that Member's care to ensure continuity of care. [State Contract § 28.7]

d. If any Covered Service provided by Provider/Subcontractor requires 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). Provider/Subcontractor shall retain that form in the event of an audit and a copy shall be submitted to the State upon request. [State Contract § 31.1]

e. If a Member changes PCPs, Provider/Subcontractor shall forward the medical records or copies thereof to the new PCP or provider within ten (10) days of the request. The PCP shall have the Member sign a release of medical records before a medical record transfer occurs. [State Contract § 39.1]

29. Licensing Requirements; Malpractice Insurance.

a. Provider/Subcontractor shall be properly licensed in accordance with all applicable State laws and regulations and shall have in effect a current policy of malpractice insurance as Company may require. [State Contract, Appendix J]

b. Provider/Subcontractor shall comply with Company's verification of Provider/Subcontractor's credentials and insurance coverage, including without limitation completing a credentialing application in accordance with the State's policies and procedures. [907 KAR 17:015, § 4; State Contract, Appendix J]

c. Provider cannot enroll or continue participation in Company's network if Provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if the Provider's required licenses and certifications are not current, if the Provider owes money to the Medicaid Program, if the office of the Attorney General has an active fraud investigation involving the Provider, or if the Provider otherwise fails to satisfactorily complete the credentialing process. [State Contract § 29.3]

30. Disclosure of Ownership and Control.

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in federal health care programs, or is 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, Provider/Subcontractor shall disclose to Company: any required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest information; and information on any criminal convictions regarding Provider/Subcontractor and any owner(s) and managing employee(s) at the time this Agreement is executed and annually thereafter, and any time there are changes to such information. [State Contract § 38.15]

b. No Provider, no individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider, and no officer, director, agent, or managing employee (*i.e.*, general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over that Provider or who directly or indirectly conducts the day-to-day operation of that Provider) shall be an entity or individual: (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)–(3) of the Social SecurityAct (42 U.S.C. § 1320a-7(b)(1)–(3)); (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a State health care program. [State Contract § 3.6]

31. Orientation and Training. Provider shall require its officers and medical staff to attend initial orientation conducted by Company within thirty (30) days after Provider is placed on active status, and shall require

same to attend any ongoing orientation and education required by Company as necessary to ensure full compliance with the State Contract and all applicable federal and State requirements. [907 KAR 17:015, § 7; State Contract § 28.5]

32. Advances and Loans. Company shall not, without thirty (30) days' prior written notice to and approval of State, make any advances to Subcontractor (not including capitation payments or payments made by Company to Company's network for the provision of Covered Services). [State Contract § 13.4]

33. Marketing Activities. Provider/Subcontractor shall comply with all allowable and unallowable marketing activities and practices pursuant to 42 C.F.R. § 438.104, and shall submit to Company for its review any marketing or information materials of Provider/Subcontractor that relate to the State Contract, prior to disseminating same. The State shall have the same approval authority for Subcontractor marketing materials as over Company's materials. [State Contract §§ 26.1, 26.2]

34. Advance Medical Directives. If Provider is a PCP, Provider shall have the responsibility to discuss advance medical directives with all adult Members at the first medical appointment of a Member and chart that discussion in the medical record of such Member. [State Contract §§ 28.3 & 28.8]

35. Accounting System. Provider/Subcontractor shall maintain its accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted systems of accounting. The accounting system shall clearly document all financial transactions between Company and Provider/Subcontractor. These transactions shall include, but not be limited to, claims payment, refunds, and adjustment of payments. [State Contract § 38.14]

36. Compliance with Laws. Provider/Subcontractor shall adhere to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; the Americans with Disabilities Act of 1990, as amended; the Rehabilitation Act of 1973, as amended; Sec. 202 of Executive Order 11246, as amended; and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. Provider/Subcontractor shall not discriminate in the rendering of services to and/or employment of individuals because of race, gender, color, religion, sex, age, national origin, sexual orientation, gender identity, handicap, political beliefs, disabled veteran status, veteran status, or any other non-merit factor. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor, through quality-assurance audits and otherwise, Subcontractor's compliance with the nondiscrimination provisions set forth in this Kentucky Medicaid Addendum. Subcontractor must also comply with the rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741, and regulations of the United States Department of Labor recited in 20 C.F.R. Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*) and its implementing regulation at 45 C.F.R. Part 80, Provider/Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement. Provider/Subcontractor's locations shall meet all requirements of the Americans with Disabilities Act and all State and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures that are applicable to health care facilities. [State Contract §§ 5.3, 5.4]

37. State Hold Harmless. Provider/Subcontractor shall indemnify, defend, save, and hold harmless the State and its officers, agents, and employees (collectively, the "State Indemnified Parties") from all claims, demands, liabilities, suits, judgments, or damages, including court costs and attorney fees made or asserted against or assessed to the State Indemnified Parties, arising out of or connected in any way with the State Contract or the performance or nonperformance by Company, by Provider/Subcontractor, or by any officers, agents, employees, suppliers, subcontractors, or providers of any of the foregoing, including without limitation any claim attributable to:

a. The improper performance of any service, or improper provision of any materials or supplies, irrespective of whether the State knew or should have known such service, supplies, or materials were improper or defective;

b. The erroneous or negligent acts or omissions, including without limitation the disregard of federal or State law or regulations, irrespective of whether the State knew or should have known of such erroneous or negligent acts;

c. The publication, translation, reproduction, delivery, collection, data processing, use, or disposition of any information to which access is obtained pursuant to the State Contract in a manner not authorized by the State Contract or by federal or State law or regulations, irrespective of whether the State knew or should have known of such publication, translation, reproduction, delivery, collection, data processing, use, or disposition; or

d. Any failure to observe federal or State law or regulations, including but not limited to insurance and labor laws, irrespective of whether the State knew or should have known of such failure.

[State Contract § 13.2]

Individual Sites Regulatory Compliance Addendum - Exhibit B-6

New Jersey Medicaid Regulatory Compliance Addendum – Subcontractor

This New Jersey Medicaid Regulatory Compliance Addendum, including the attached Attachment 1, MacBride Principles Certification Form, ("Addendum") is incorporated by reference into the Agreement. If there is any conflict between the terms of this Addendum and any other term of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, if there is any conflict between the terms of the Agreement, including this Addendum, and the State Contract, as amended, then the terms of the State Contract will govern and control.

For purposes of this Addendum, the term "Subcontractor" shall mean the party executing the Agreement, as identified on the first page of the Agreement, which may be a health care physician, provider, group, facility, hospital, individual, entity or a delegated entity. For purposes of this Addendum and the State Contract, the term "Contractor" and shall mean Company.

Notwithstanding any other provision of the Agreement, for purposes of this Addendum, "State Contract" means only the State of New Jersey Department of Human Services ("DHS"), Division of Medical Assistance and Health Services ("DMAHS") and Aetna Better Health Inc. Contract to Provide Services, entered into November 17, 2014, and as amended from time to time. "Department" refers to either DMAHS or the New Jersey Department of Banking and Insurance ("DOBI"), as applicable.

Capitalized terms not otherwise defined in the Agreement, or its attachments, shall have the meaning ascribed to them in the State Contract or under applicable law.

To the extent applicable to the services provided by Subcontractor under the Agreement, the parties agree as follows:

1. **DMAHS Mandatory Terms**

Subcontractor agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions, to the extent applicable to the services provided under the Agreement:

A. SUBJECTION OF AGREEMENT

The Agreement shall be subject to the applicable material terms and conditions of the State Contract between the Company and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Company.

MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Company's provider network requirements shall be included in Company's provider network to

serve MLTSS Members. In addition, if Company wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. Company must accept all NFs, SCNF, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be for a two year period from the date that the service comes into MLTSS, dependent upon available appropriation in each Fiscal Year. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2016. Thereafter, Company may determine the continuing provider network status of these provider types based on Member utilization and access needs. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation and (b) the negotiated rate between the Company and the facility. This does not preclude volume-based rate negotiations and agreement between the Company and these providers.
2. The Any Willing Plan status also expires June 30, 2016.
3. Long term care pharmacy status as an Any Willing Provider shall not expire. Company shall pay long term care pharmacies the rate negotiated between the Company and the pharmacy.

Claims payment for services to MLTSS Members. Company shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS providers, adult/pediatric medical day care providers, PCA and participant directed Vendor Fiscal/Employer Agent Financial management Services (VF/EA FMS) claims within the following timeframes:

1. HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;
2. Manually submitted clean claims shall be processed within thirty (30) calendar days of receipt.

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

Subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and state laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

1. Subcontractor shall submit claims within 180 calendar days from the date of service.
2. Subcontractor shall submit corrected claims within 365 days from the date of service.
3. Subcontractor shall submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

C. APPROVAL OF AGREEMENT AND AMENDMENTS

Subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove the Agreement and any amendments thereto.

If applicable and required, Company and any AWP provider shall only amend the Agreement unilaterally for statutory and regulatory changes, and upon mutual consent of the Parties with State approval.

D. EFFECTIVE DATE

The Agreement shall become effective only when the State Contract takes effect.

E. NON-RENEWAL/TERMINATION OF AGREEMENT

Subcontractor understands that the Company shall notify DMAHS at least 45 days prior to the effective date of the suspension, termination, or voluntary withdrawal of Subcontractor from participation in Company's network. If the termination was "for cause," Company's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless Company can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers. [State Contract Section 4.9.3 B]

F. ENROLLEE-PROVIDER COMMUNICATIONS

1. Company shall not prohibit or restrict Subcontractor from engaging in medical communications with Subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between Subcontractor and Subcontractor's patient. Subcontractors shall be free to communicate freely with their patients about the health status of their patients, medical care, or treatment options regardless of whether benefits for that care or treatment are provided under the Agreement, if the professional is acting within the lawful scope of practice. Subcontractors shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.
2. Nothing in Section F.1 shall be construed:
    a. To prohibit the enforcement, including termination, as part of a subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by Company to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider, but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between subcontractors and their patients; or
    b. To permit a health care provider to misrepresent the scope of benefits covered under the Agreement or to otherwise require Company to reimburse subcontractors for benefits not covered.

G. RESTRICTION ON TERMINATION OF AGREEMENT BY COMPANY

Termination of AWP providers is limited to State ordered termination as indicated in Section H below. Company shall not terminate the Agreement for either of the following reasons:

1. Because Subcontractor expresses disagreement with Company's decision to deny or limit benefits to a covered person or because Subcontractor assists the covered person to seek reconsideration of the Company's decision; or because Subcontractor discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by Company or not, policy provisions of Company, or Subcontractor's personal recommendation regarding selection of a health plan based on Subcontractor's personal knowledge of the health needs of such patients.

2. Because Subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because Subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. TERMINATION OF AGREEMENT – STATE

Subcontractor understands and agrees that the State may order the termination of the Agreement if it is determined that Subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;
2. Takes any action that threatens the fiscal integrity of the Medicaid program;
3. Has its certification suspended or revoked by DOBI, DOH, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;
4. Becomes insolvent or falls below minimum net worth requirements;
5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;
6. Materially breaches the Agreement; or
7. Violates state or federal law, including laws involving fraud, waste, and abuse.

I. NON-DISCRIMINATION

Subcontractor shall comply with the following requirements regarding nondiscrimination:

1. Subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.
2. ADA Compliance. Subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, Subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are "qualified individuals with a disability" covered by the provisions of the ADA. Company shall supply a copy of its ADA compliance plan to Subcontractor.

   A "qualified individual with a disability" as defined pursuant to 42 U.S.C.§12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

   Subcontractor shall submit to Company a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that Subcontractor meets ADA requirements to the best of Subcontractor's knowledge. Subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of Subcontractor to be in compliance with the ADA. Where applicable, Subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.
3. Subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to

Subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4. Subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1 through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. Subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this Subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This nondiscrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.

6. Grievances. Subcontractor agrees to forward to Company copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by Subcontractor.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF THE COMPANY'S INSOLVENCY AND TO HOLD ENROLLEES AND FORMER ENROLLEES HARMLESS

1. Subcontractor shall remain obligated to provide all services for the duration of the period after Company's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

2. Subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by Company or the state, insolvency of Company, or breach of agreement) will Subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in Section P below.

3. Subcontractor agrees that this provision shall survive the termination of the Agreement regardless of the reason for termination, including insolvency of Company, and shall be construed to be for the benefit of Company or enrollees.

4. Subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.

5. Subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.

6. Subcontractor shall comply with the prohibition against billing members contained in 42 CFR 438.106, N.J.S.A. 30:4D-6.c, and N.J.A.C. 10:74-8.7.

K. INSPECTION

1. Subcontractor shall allow the New Jersey Department of Human Services (DHS), the U.S. Department of Health and Human Services (DHHS), and other authorized State agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the Agreement, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by Subcontractor pertaining to such services, at any time during normal business

hours (and after business hours when deemed necessary by DHS or DHHS, or MFD) at a New Jersey site designated by the State. Inspections may be unannounced for cause.

2. Subcontractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by Subcontractor, prior to approval of their use for providing services to enrollees.

3. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under the Agreement, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to enrollees. Upon request, at any time during the period of the Agreement, Subcontractor shall furnish any such record, or copy thereof, to the Department or the Department's External Review Organization within 30 days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.

4. The DMAHS, the MFD, or its designee, and the MFCU, shall have the right to inspect, evaluate, and audit all of the following documents in whatever form they are kept, related to the Agreement:

   a. Financial records, including but not limited to tax returns, invoices, inventories, delivery receipts, Medicaid claims;

   b. Medical records, including but not limited to medical charts, prescriptions, x-rays, treatment plans, medical administration records, records of the provision of activities of daily living, ambulance call reports;

   c. Administrative documents, including but not limited to credentialing files, appointment books, prescription log books, correspondence of any kind with Company, DMAHS, CMS, any other managed care contractor, Medicaid recipient, contracts with subcontractors, and contracts with billing service providers; and

   d. All records required to be kept to fully disclose the extent of services provided to Medicaid recipients, pursuant to NJAC 10:49-9.8(b) (1).

L. RECORD MAINTENANCE

Subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. RECORD RETENTION

Subcontractor hereby agrees to maintain an appropriate recordkeeping system for services to enrollees. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary and make that information readily available to appropriate health professionals and the Department. Records must be retained for the later of:

1. Five (5) years from the date of service, or

2. Three (3) years after final payment is made under the Agreement and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the Company, Subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 1.R., Confidentiality, and at no cost to the enrollee.

N. DATA REPORTING

Subcontractor agrees to provide all necessary information to enable Company to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. DISCLOSURE

1. Subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of Company's agreement with the State.
2. Subcontractor shall comply with financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.
3. Subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106 and complete a disclosure statement which will be maintained by Company.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

Subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A and B enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with applicable law. Any such contributions shall be set forth in an attached schedule.

Q. INDEMNIFICATION BY SUBCONTRACTOR

1. Subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of the Agreement.
2. Subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of the Agreement.
3. Subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which Subcontractor receives payment.
4. Subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under the Agreement, or for any libelous or otherwise unlawful matter contained in such data that Subcontractor inserts.
5. Subcontractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of Subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. Subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by Subcontractor.

R. CONFIDENTIALITY

1. General. Subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of Subcontractor and Company and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.4. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of the Agreement including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by Company's Plan that are eligible through the Division of Youth and Family Services, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by Subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of the Agreement; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than the Department without the Department's prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the Agreement, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. Subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within Subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of the Agreement.

5. The provisions of this Section R shall survive the termination of the Agreement and shall bind Subcontractor so long as Subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, Subcontractor is responsible for complying, at a minimum, with the following statues and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U.S.C. 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. CLINICAL LABORATORY IMPROVEMENT

Subcontractor shall ensure that all laboratory testing sites providing services under the Agreement have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. FRAUD, WASTE, AND ABUSE

1. Subcontractor agrees to assist Company as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.

2. If the State has withheld payment and/or initiated a recovery action against Subcontractor, or withheld payments pursuant to 42 CFR 455.23 and NJAC 10:49-9.10(a), Company shall have the right to withhold payments from Subcontractor and/or forward those payments to the State.

3. Company and its providers, and subcontractors, whether or not they are enrolled Medicaid providers, shall cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DOH, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. Company shall include language in its contracts with its providers and subcontractors, requiring cooperation, and stating that a failure to cooperate shall be grounds for termination of Company's Agreement with provider or subcontractor. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

4. MFD shall have the right to recover directly from providers and enrollees in the Company's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with Company, but reported to DMAHS in the format that the Company reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the Company to withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by Company shall be sent to MFD from Company and reported to DMAHS in the format that Company reports its recoveries to DMAHS.

5. Company shall have the right to recover directly from providers, subcontractors and enrollees in Company's network for the audits and investigations the Company solely conducts.

U. THIRD PARTY LIABILITY

1. Subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.

2. Except as provided in subsection 3. below, if Subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to Company.

3. In the following situations, Subcontractor may bill Company first and then coordinate with the liable third party, unless Company has received prior approval from the State to take other action.

    a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.

    b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.

    c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.

    d. The claim is for a child who is in a DCP&P supported out of home placement.

    e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.

4. If Subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, Subcontractor may bill Company without having received a written denial from the third party.

5. Sharing of Third Party Liability (TPL) Information by Subcontractor.

    a. Subcontractor shall notify the Company within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by Company, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.

    b. When Subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, Subcontractor shall notify

Company in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in Subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee's diagnosis and the nature of the service provided to the enrollee.

c. Subcontractor shall notify Company on no less than a weekly basis when it becomes aware of the death of one of its Medicaid enrollees age 55 or older, utilizing the "Combined Notification of Death and Estate Referral Form" located in subsection B.5.1 of the Appendix of the State Contract, as it may be amended from time to time.

d. Subcontractor agrees to cooperate with Company's and the State's efforts to maximize the collection of third party payments by providing to Company updates to the information required by this Section.

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's or subcontractor's sole recourse for payment, other than collection of any authorized cost-sharing, patient payment liability and /or third party liability, is Company, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

   a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

   b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

   c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i), 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section and/or NJAC 10:74-9.1 and 4.2.1D.2 of the contract), or NJAC 10:74-9.1; and

   d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and

   e. The protections afforded to enrollees under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

   f. The provider has received no program payments from either DMAHS or Company for the service; or

   g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

   a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in Company's network; or

   b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

2. **Miscellaneous DMAHS Terms Required by Law or State Contract**

A. DEFINITIONS. The definition of "Clean Claim" in the Agreement is stricken and replaced with:

"A claim by Provider where 1) the claim is for a service or supply covered by the Member's Plan; 2) the claim is submitted with all the information requested by Company or in other instructions; 3) the person to whom the service or supply was provided was a Member on the date of service; 4) Company does not reasonably believe that the claim has been submitted fraudulently; and 5) the claim does not require special treatment. For the purposes of this definition, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. In order to accept a claim, the information requested by Company is specified in its Policies, which include the requirements that a claim have (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, and (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-9, 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). Further information on the type of information and documentation that must be submitted with a claim, including a standard claim form and any other claim submission requirements utilized by the carrier for both manually and electronically submitted claims, and a street address where claim submissions can be delivered by hand or registered/certified mail, is available in Company's Policies and/or its website."

B. Insurance. To the extent applicable, Subcontractor must obtain appropriate insurance coverage, including professional malpractice insurance, comprehensive general liability insurance, and automobile liability insurance. The minimum coverage for malpractice insurance shall be $1,000,000 per incident/$3,000,000 aggregate. Subcontractor agrees that any insurance obtained by Subcontractor shall not limit Subcontractor's indemnification of the State and enrollees.

C. Cooperation. Subcontractor must cooperate and participate in Company's quality management and utilization management system, including credentialing/recredentialing; appointment standards; and enrollee and provider complaint and grievance system.

D. Equality of Access. To the extent applicable, Subcontractor shall provide the same level of medical care and health service to DMAHS enrollees as it does to enrollees under private or group contracts.

E. Monitoring.

1. Monitoring by Company. The responsibilities performed by Subcontractor are monitored on an ongoing basis and Company is ultimately responsible to the HHS for the performance of all services. Company is responsible for ensuring that the performance of Subcontractor is consistent with the State Contract. Company has the right to revoke the Agreement if Subcontractor does not perform satisfactorily, subject to the termination provisions herein.

2. Monitoring/Enforcement by State. HHS may require Company to terminate the Agreement if performance is not consistent with the State Contract.

F. Severability. Any determination that any provision of the 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 the Agreement. Neither Party shall assert or claim that the Agreement or any provision hereof is void or voidable if such part performs under the Agreement without prompt and timely written objection.

G. MacBride Principles Certification Form. Subcontractor must execute the MacBride Principles Certification Form included in Attachment 1.

3. **New Jersey Department of Banking and Insurance (DOBI) Required Terms**. The following terms and conditions apply only to the Agreement if it relates to the provision of health care services or supplies by Subcontractor. These terms are not applicable if the Agreement pertains to purely administrative services provided by Subcontractor on behalf of Company. Subcontractor agrees that all contracts that Subcontractor has with providers in accordance with the terms of the Agreement shall specifically refer to and contain all of the provisions set forth in NJAC 11:24-15 and require that its providers comply with all of the terms and conditions set forth therein.

   A. **Licensure/Certification.** Subcontractor shall maintain appropriate licensure and certifications required in order to perform its obligations under the Agreement.

   B. **No Violation of Law.** The Agreement shall not be interpreted to impose obligations or responsibilities upon Subcontractor which require Subcontractor to violate the statutes or rules governing licensure of Subcontractor if Subcontractor is to comply with the terms of the Agreement.

   C. **Notice of Termination.** To the extent applicable, if the Agreement between Company and Subcontractor is terminated by Company on any date other than the designated renewal date unless termination was made by mutual agreement of the Parties, Company shall give Subcontractor at least ninety (90) days prior written notice of the termination and the opportunity to request a hearing in all instances except when the termination is based upon non-renewal of the Agreement, a determination of fraud, breach of contract by Subcontractor, sanctions by a state or federal agency, or the opinion of Company's medical director that Subcontractor represents an imminent danger to a Member or the public health, safety and welfare. The notice of termination shall specify: (a) that Subcontractor may request in writing from Company, within fifteen (15) days of receipt of the notice, a written reason for the termination unless such reason is already stated in the notice, (b) that Subcontractor may request a hearing, and; (c) the procedures for exercising Subcontractor's right to a hearing. Subcontractor's participation in the hearing process shall not be deemed an abrogation of Subcontractor's legal rights. No termination, expiration, change, amendment, alteration, modification, assignment, delegation or waiver shall be effective unless such termination, expiration, change, amendment, alteration, modification, assignment, delegation or waiver is filed with the New Jersey Department Banking and Insurance at least thirty (30) days prior to the proposed effective date.

   D. **Pricing Following Termination.** To the extent applicable, Subcontractor shall continue to provide services to members at the contract price following termination of the Agreement, in accordance with N.J.A.C. 11:24-3.5.

   E. **Secondary Contractors.** To the extent Subcontractor is or acts as a secondary contractor (as defined in Section 11:24-1.2 of the New Jersey Administrative Code), Company is a third party beneficiary of the secondary contractor's contract(s) with the health care providers, and Subcontractor's contract(s) with health care providers shall provide that Company shall have privity of contract with the health care providers such that Company shall have standing to enforce Subcontractor's contract(s) with the health care providers in the absence of enforcement by Subcontractor. All Subcontractor's agreements with health care providers shall be consistent with laws regarding confidentiality of information and with professional licensing standards, including, but not limited to, New Jersey Statutes Sections 45:14B-31 et seq. and 11:24-15.2(b-e) of the New Jersey Administrative Code. Such contracts shall include a provision whereby the provider is required to hold Members harmless for the cost of any service or supply covered by Company, subject to Section 11:24-15.2(b)(7)(i & ii), whether or not the provider believes the compensation received is adequate. Company reserves the right to enter into separate contracts directly with such health care providers, as set out in NJAC 11:24-15.2(g).

      Notwithstanding the foregoing sentence, the rights of Company as a third party beneficiary and of privity of contract with respect to Subcontractor's contracts with heath care providers in no way limit Subcontractor's obligations to enforce the terms of such contracts nor shall such rights be construed in any way to impose an obligation on Company to enforce such contracts.

4. **Pharmacy Subcontracts**

A. If the Agreement is for the provision of pharmacy services or supplies by Subcontractor than the Agreement must comply with N.J. Stat. 26:2J-4.7 and all the terms and conditions of the Agreement are subject to the provisions set forth in N.J.A.C. 11:24-18.

B. All services or other activity performed by downstream entity in connection with each Medicare Part D Plan shall be consistent and comply with each Medicare Part D Plan's CMS Contract. 42 CFR 423.505(i)(3)(iii).

C. All contracts related to Medicare Part D services and activities shall describe the payment the downstream entity will receive for performance under the contract, if applicable.

D. All contracts related to Medicare Part D services and activities shall be for a term of at least the initial one-year contract period (i.e., January 1 through December 31), or such longer time period required by CMS. Where the contract is for services or products to be used in preparation for the next contract year's Part D operations (e.g., marketing, enrollment), the initial term of such contract shall include this period of performance (e.g., contracts for enrollment-related services shall have a term beginning no later than October 15 extending through the full contract year ending on December 31 of the next year). The Parties acknowledge that this contract is for a term of the longer of: (i) one year, and (ii) the first year of Part D Operations of the Medicare Part D Plan.

E. All contracts related to Part D services and activities shall be signed by a representative of each Party with legal authority to bind the entity.

F. Downstream entity shall comply with and abide by all applicable Federal and State laws, regulations, and CMS instructions. 42 CFR 423.505(i)(4)(iv).

G. Downstream entity agrees to comply with and abide by State and Federal privacy and security requirements, including the confidentiality and security provisions stated in the regulations at 42 CFR 423.136.

H. Downstream entity shall make its books and other records available in accordance with 42 CFR 423.505(e)(2) and 42 CFR 423.505(i)(2). In this regard, HHS, the Comptroller General, and their designees shall have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation involving transactions related to Plans' CMS Contracts and these rights continue for a period of 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. HHS, the Comptroller General, and their designees shall have direct access (e.g., on site access) to the downstream entity, and the downstream entity will make such books and records directly available to HHS, the Comptroller General, or their designee for such inspection, evaluation, and audit. 42 CFR 423.505(e)(2) and (i)(2).

I. Downstream entity shall not hold Members liable for payment of any fees that are the responsibility of Plans, Subcontractor, or any downstream entity. 42 CFR 423.505(i)(3)(i).

J. Downstream entity shall provide directly to CMS or its designees any books, contracts, records, including medical records and documentation relating to the Part D program. 42 CFR 423.505(i)(3)(iv).

K. In the event CMS or Plans determine that a downstream entity has not performed satisfactorily under the Agreement, CMS and/or the Plans may revoke (if applicable, subject to the default provisions agreed to therein) the delegated activities and responsibilities of the downstream entity. 42 CFR 423.505(i)(4)(ii).

L. Plans will establish and maintain ongoing monitoring and oversight of all aspects of the downstream entity's performance of its obligations in connection with the Medicare Part D Plan. 42 CFR 423.505 (i)(4)(iii).

M. To the extent downstream entity establishes the pharmacy network or selects pharmacies to be included in the network, downstream entity agrees each Plan has the right to approve, suspend, or terminate any arrangement with a participating pharmacy. 42 CFR 423.505(i)(5).

N. To the extent downstream entity establishes the pharmacy network or selects pharmacies to be included in the network, downstream entity shall issue, mail, or otherwise transmit payment with respect to all clean Part D claims submitted by or on behalf of pharmacies (other than pharmacies that dispense drugs by mail order only or are located in, or contract with, a long-term care facility) within fourteen (14) days of receipt of an electronically submitted claim or within thirty (30) days of receipt of a claim submitted otherwise. 42 CFR 423.505(i)(3)(vi) and 42 CFR 423.520.

O. To the extent downstream entity establishes the pharmacy network or selects pharmacies to be included in the network, downstream entity shall utilize Medi-Span as the source for the prescription drug pricing standard of reimbursement (i.e., AWP pricing). 42 CFR 423.505(b)(21) and 423.505(i)(3)(viii)(B).

P. To the extent downstream entity establishes the pharmacy network or selects pharmacies to be included in the network, downstream entity shall update the prescription drug pricing standard of reimbursement (i.e., AWP pricing) in the online claims adjudication system no less frequently than once every seven (7) days (beginning with an initial update on January 1 of each year) to accurately reflect the market price of acquiring the drug as reflected by Medi-Span. 42 CFR 423.505(b)(21) and 423.505(i)(3)(viii)(A).

Q. To the extent downstream entity establishes the pharmacy network or selects pharmacies to be included in the network, downstream entity shall require participating pharmacies to submit claims to Plan or its designated downstream entity whenever the Member identification card is presented or on file at the participating pharmacy unless the Member expressly requests that a particular claim not be submitted. 42 CFR 423.120(c)(3).

R. To the extent downstream entity adjudicates and processes claims at the point of sale and/or negotiates with prescription drug manufacturers and others for rebates, discounts, or other price concessions on prescription drugs, downstream entity shall comply with the reporting requirements established in 42 CFR 423.514(d) and (e).

S. Claims data and information provided in connection with the Agreement is used for purposes of obtaining Federal funds. Downstream entity agrees that it is bound by 2 CFR Part 376 and represents and warrants that it is not excluded by the DHHS, OIG, or by the General Services Administration.

T. In accordance with 42 CFR 423.505(k)(3), downstream entity must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the Claims data related to payment.

U. In accordance with 42 CFR 423.505(i)(1) and 42 CFR 423.562(a)(4), notwithstanding anything to the contrary agreed to by the Parties, Medicare Part D Plans maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of their CMS Contracts and for ensuring that downstream entities satisfy their obligations under their respective Medicare Part D Plans.

V. In accordance with 42 CFR 423.505(d), downstream entity agrees to maintain for ten (10) years, books, records, and documents related to the performance of its obligations with respect to Plans' Medicare Part D Plans.

W. At the time of hire and on an annual basis thereafter, downstream entity shall have all individuals involved in the provision of services hereunder participate in fraud, waste, and abuse training in accordance with 42 C.F.R. Section 423.504(b)(vi). Downstream entity will provide a copy of such training materials and proof that the training has been completed upon request of a Plan.

X. Downstream entity shall have effective lines of communication related to detecting, correcting, and preventing fraud, waste, and abuse in accordance with 42 C.F.R. Section 423.504(b)(vi).

Y. In the event downstream entity has offshore contractor arrangements involving the receipt, processing, transfer, handling, storage, or access to Member PHI, downstream entity shall provide such information as is required in order for Plans to update such information in the HPMS Offshore Subcontracting module in accordance with CMS requirements.

ATTACHMENT 1
MACBRIDE PRINCIPLES CERTIFICATION FORM

COMPLETE THIS CERTIFICATION IN COMPLIANCE WITH MACBRIDE PRINCIPLES AND NORTHERN IRELAND ACT OF 1989

Pursuant to Public Law 1995, c.134, a contractor must complete the certification below by checking one of the two representations listed and signing where indicated.

I certify, pursuant to N.J.S.A. 52:34-12.2 that the entity for which I am authorized to contract:

____ has no ongoing business activities in Northern Ireland and does not maintain a physical presence therein through the operation of offices, plants, factories, or similar facilities, either directly or indirectly, through intermediaries, subsidiaries or affiliated companies over which it maintains effective control; or

____ will take lawful steps in good faith to conduct any business operations it has in Northern Ireland in accordance with the MacBride principles of nondiscrimination in employment as set forth in N.J.S.A. 52:18A-89.5 and in conformance with the United Kingdom's Fair Employment (Northern Ireland) Act of 1989, and permit independent monitoring of their compliance with those principles.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature:

_____
Authorized Signature

_____
Print Name

_____
Title

_____
Date

Firm Name: Cotiviti LLC

PENNSYLVANIA REGULATORY COMPLIANCE ADDENDUM (SUBCONTRACTOR)

This Pennsylvania Regulatory Compliance Addendum is incorporated by reference in the Agreement. It is intended to supplement the requirements set forth in the Agreement. If there is any conflict between the express terms of this Addendum and the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, that if there is any conflict between the express terms of the Agreement, including this Addendum, and the applicable State Contract, then the terms of the applicable State Contract will govern and control.

For purposes of this Addendum, the term "Subcontractor" shall mean an entity that contracts with Company to perform part of the Company's responsibilities under the applicable State Contract. In the event that any provision of this Addendum is construed under the applicable State Contract and in accordance with applicable laws and regulations as inapplicable to Subcontractor, then such provision shall not apply.

Company and Subcontractor agree to abide by all applicable provisions of the applicable State Contract with the Pennsylvania Department of Human Services. Subcontractor compliance with the applicable State Contract specifically includes, but is not limited to, the requirements contained herein. Notwithstanding anything in Section 9.1 of the Agreement ("Amendments"), if any provision of a State Contract is amended to reflect a change in federal, state, or local laws, regulations, or program requirements, then the provisions of this Addendum that correspond to such amended provisions of the State Contract shall also be deemed automatically amended, without further action by any party. Furthermore, the Subcontractor agrees to perform its obligations under the Agreement in full compliance with all forthcoming and applicable statutes, regulations, program requirements and other guidance issued by the Pennsylvania Department of Human Services and/or the Pennsylvania Insurance Department.

1.0 DEFINITIONS

All capitalized terms in this Addendum shall have the meaning set forth in the Agreement unless otherwise defined herein, in which case the definitions contained in this Addendum shall control. Capitalized terms not defined herein or in the Agreement shall have the definition set forth in the applicable State Contract.

1.1 Department. Pennsylvania Department of Human Services. (*HealthChoices Agreement Section II; Community HealthChoices Agreement Section II.*)

1.2 Encounter Data. A record of any covered health care service provided to a Member in the HealthChoices Program and includes Encounters reimbursed through Capitation, Fee-for-Service, or other methods of compensation regardless of whether payment is due or made. (*HealthChoices Agreement Section II; Community HealthChoices Agreement Section II.*)

1.3 HealthChoices Program. The Pennsylvania 1915(b) waiver program to provide mandatory managed health care to Recipients. (*HealthChoices Agreement Section II.*)

2.0 REQUIREMENTS FOR PENNSYLVANIA HEALTHCHOICES

The provisions of this Section 2 apply to any Agreement that relates to a State Contract that is a HealthChoices Agreement.

2.1 Definitions. For the purposes of this Section 2, the following definition shall apply:

a. Medically Necessary or Medical Necessity. A service or benefit is Medically Necessary if it is compensable under the Medical Assistance Program and if it meets any one of the following standards:

i. The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

ii. The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

iii. The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

(*HealthChoices Agreement Section II; Community HealthChoices Agreement Section II.*)

2.2 Compliance.

a. *Applicable Law.* Subcontractor shall comply with all applicable federal and state laws and the State Contract. Without limiting the foregoing, Subcontractor shall meet the applicable requirements of 42 C.F.R. Subsection 434.6. Subcontractor shall take such actions as are necessary to permit Company to comply with the Fraud, Waste, and Abuse Requirements of the State Contract. (*HealthChoices Agreement Section XIII(A)(2); HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement Section V(X)(2); HealthChoices Agreement Section V(O)(6)(o); Community HealthChoices Agreement Section XIII(A)(2); Community HealthChoices Agreement, Exhibit V; Community HealthChoices Agreement Section V(X)(4)(o).*)

b. *Derivation of Funds.* Subcontractor recognizes that payments made to Subcontractor are derived from federal and state funds. (*HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.*)

c. *False Claims or Statements.* Subcontractor acknowledges that it may be subject to sanctions in connection with violations of federal and state laws and regulations related to the Agreement, the services provided hereunder, and the submission of false claims and statements. (*HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.*)

d. *Nonperformance, Misrepresentation, Fraud, or Abuse.* To the extent Subcontractor renders services to Members, Subcontractor shall be held civilly and/or criminally liable to both Company and the Department, in the event of nonperformance, misrepresentation, fraud, or abuse. (*HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.*)

e. *Prohibition against Gag Clauses.* To the extent Subcontractor provides medical services to Members, Subcontractor is prohibited from consenting to gag clauses which limit Subcontractor's disclosure of medically necessary or appropriate health care information or alternate therapies to Members, other healthcare professionals, or the Department. The State Contract further prohibits gag clauses which limit employees' disclosure of information pertaining to the HealthChoices Program. (*HealthChoices Agreement Section XIII(A)(3); HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement Section XII(A)(3); Community HealthChoices Agreement, Exhibit V.*)

f. *Sanctions.* The specific activities and report responsibilities delegated to Subcontractor are set forth in the Agreement. Company may revoke delegation or impose sanctions if Subcontractor's performance is inadequate. (*HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.*)

2.3 Member Complaint, Grievance, and Fair Hearing Process. Subcontractor shall comply with the Member Complaint, Grievance, and Fair Hearing Process. This includes reporting requirements established by Company. There must be no delegation of the Complaint, Grievance and Fair Hearing process to a subcontractor without prior written approval of Company. (*HealthChoices Agreement Section V(I)(1); Community HealthChoices Agreement Section V(R)(1).*)

2.4 Quality Management / Utilization Management. Subcontractor shall cooperate with Quality Management / Utilization Management Program requirements. To the extent that Subcontractor conducts Utilization Management activities, compensation and payments to Subcontractor may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member, and Subcontractor shall process each request for benefits in compliance with Company's prior authorization policies and procedures, as approved by the Department. (*HealthChoices Agreement, Exhibit II; HealthChoices Agreement Section V(T)(6); HealthChoices Agreement Section XIII(A)(7); Community HealthChoices Agreement, Exhibit V; Community HealthChoices Agreement Section V(CC)(8); Community HealthChoices Agreement Section XII(A)(7).*)

2.5 Performance Deficiencies. Company shall monitor Subcontractor's performance on an on-going basis and subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State laws and regulations. If Company identifies deficiencies or areas needing improvement, Subcontractor shall take corrective action. (*HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.*)

2.6 Confidential Information. Subcontractor shall implement mechanisms that guard against unauthorized or inadvertent disclosure of confidential information to persons outside the Company. Subcontractor shall comply with applicable federal and state laws regarding confidentiality of medical records. The federal and state laws with regard to confidentiality of medical records include, but are not limited to: Mental Health Procedures Act, 50 P.S. 7101 et seq.; Confidentiality of HIV-Related Information Act, 35 P.S. 7601 et seq.; 45 C.F.R. Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information); and the Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. 1690.101 et seq., 42 U.S.C. § 1396a(a)(7); 62 P.S. 404; 55 Pa. Code 105.1 et seq.; and 42 C.F.R. 431 et seq. Subcontractor shall not use or disclose any information about a Member or the services to be provided under the Agreement for any purpose not connected with the responsibilities set forth in the Agreement except with the written consent of such Member, Member's attorney, or Member's parent or legal guardian. (*HealthChoices Agreement Sections V(T)(8) and XIV(A); HealthChoices Agreement at DHS Addendum to Standard Contract Terms and Conditions, Section B; Community HealthChoices Agreement at DHS Addendum to Standard Contract Terms and Conditions, Section B; Community HealthChoices Agreement Section V(CC)(10).*)

2.7 Records.

a. *Books and Records.* Subcontractor shall maintain books and records relating to the HealthChoices Program services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records and prescription files. Subcontractor shall comply with all standards for practice and medical records keeping specified by the Commonwealth of Pennsylvania (Commonwealth). (*HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.*)

b. *Financial Books and Records.* Subcontractor(s) shall maintain books, records, documents and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to the Agreement as well as to all required programmatic activity and data pursuant to the Agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract

period and five years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all tasks are completed. (*HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.*)

c. *Record Retention Period.* Subcontractor shall retain all records for a period of five (5) years beyond expiration or termination of the Agreement, except that Subcontractor shall retain the source records for its data reports for a minimum of seven (7) years and must have written policies and procedures for storing this information. (*HealthChoices Agreement Section V(O)(5); HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit D at paragraph (15); Community HealthChoices Agreement Section V(X)(3); Community HealthChoices Agreement, Exhibit V.*)

d. *Access to Records.* Subcontractor shall permit the Department ready access to any and all documents and records of transactions pertaining to the provision of services to Medical Assistance consumers. (*HealthChoices Agreement Section XIII(A)(4); HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement Section XIII(A)(4); Community HealthChoices Agreement, Exhibit V.*)

e. *Audits.* Subcontractor shall, at its own expense, make all records available for audit, review, or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site, during normal business hours or through the mail. During the contract and record retention period, these records shall be available at the Company's chosen location, subject to approval of the Commonwealth. Subcontractor must fully cooperate with any and all reviews and/or audits by state or federal agencies or their agents, such as the Independent Assessment Contractor, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable. (*HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.*)

2.8 Marketing and Outreach Materials. Subcontractor shall be prohibited from distributing directly or through any agent or independent contractor, outreach materials without advance written approval of Company. Outreach materials include pamphlets and brochures which can be used by an Enrollment Assistance Program contractor to assist Recipients of Medical Assistance benefits in choosing a PH-MCO and PCP. (*HealthChoices Agreement Section V(F)(2).*)

2.9 Data Reporting.

a. *Timeliness.* To the extent Subcontractor provides medical services and receives reimbursement from Company either directly or through capitation, Subcontractor shall timely report to Company data for all services. Penalties and sanctions will be imposed for failure to comply. The data is to be included in the utilization and encounter data provided to the Department in the format required. (*HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.*)

b. *Encounter Data.* Subcontractor shall cooperate with the submission of all Encounter Data for all services provided pursuant to the Agreement, no matter whether reimbursement for these services is made by Company either directly or indirectly through capitation. (*HealthChoices Agreement Section XIII(A)(1); Community HealthChoices Agreement Section XII(A)(1).*)

c. *Change in Service or Coverage.* Subcontractor shall provide prompt written notification to Company of a denial, partial approval, reduction, or termination of service or coverage, or a change in the level of care. (*HealthChoices Agreement Section XIII(A); Community HealthChoices Agreement Section XII(A).*)

2.10 Network Composition. To the extent applicable, Subcontractor shall adhere to the standards for Network composition and adequacy. (*HealthChoices Agreement Section XIII(A)(6); Community HealthChoices Agreement Section XII(A)(6).*)

2.11 Information Systems. Subcontractors must meet the same Management Information Systems requirements as Company. Company shall provide its subcontractors with the appropriate files and information to meet this requirement (i.e., the daily eligibility file, provider files, etc.). To the extent Subcontractor provides information

systems services, Subcontractor shall prepare a transition plan in the event that Company terminates the Agreement or enters into a subcontract with a different entity. This transition plan must include information on how the data shall be converted and made available to the new subcontractor. The data must include all historical claims and service data. (*HealthChoices Agreement Section V(O)(7)(o); HealthChoices Agreement Section XIII(A)(8); Community HealthChoices Agreement Section V(X)(5)(p).*)

2.12 Third Party Resources. To the extent Subcontractor provides medical services to Members, Subcontractor shall report to Company all new third party resources identified through the provision of medical services, which previously did not appear on the Department's recipient information files. (*HealthChoices Agreement Section VII(E)(13); HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement Section VII(F)(5); Community HealthChoices Agreement, Exhibit V.*)

2.13 Hold Harmless. Subcontractor agrees to hold harmless the Commonwealth, all Commonwealth officers and employees and all Members in the event of nonpayment by Company to Subcontractor. Subcontractor shall further indemnify and hold harmless the Commonwealth and their agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Commonwealth or their agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor, its agents, officers, employees or Company. (*HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.*)

3.0 REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE PROGRAM

The provisions of this Section 3 apply to any Agreement that relates to a State Contract that is an agreement for the Pennsylvania Children's Health Insurance Program.

3.1 Definitions. For the purposes of this Section 3, the following definition shall apply:

a. Medically Necessary. A service or benefit that:
   i. Is reasonably expected to prevent the onset of an illness, condition or disability.
   ii. Is reasonably expected to reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
   iii. Assists the member to achieve maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for members of the same age.

(*CHIP Transmittal 2013-1.*)

3.2 Records Retention. Subcontractor shall maintain electronic images of all records and make these document images available upon request to Department and/or Company. Such records must be maintained in electronic imaging format and must be legible and readily retrievable and available for review, audit, or evaluation by authorized Commonwealth and/or Company personnel or their representatives. These records must be maintained for a minimum of five (5) years from the expiration date of the contract period or as otherwise required by law, except that if an audit is in progress or audit findings are yet unresolved, records shall be kept until all tasks are completed. Access shall be provided as directed by the Department and/or Company. Subcontractor shall fully cooperate with any and all reviews and/or audits by the Commonwealth, Company, and their designated representatives, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. (*CHIP Statement of Work Section S.*)

3.3 Outreach. Subcontractor shall not distribute, directly or through any agent or independent contractors, outreach materials that contain false or misleading information. (*CHIP Policy Manual Section 40.2.*)

3.4 Fraud and Abuse. Subcontractor recognizes that payments made pursuant to the Agreement are derived from government funds. Subcontractor is prohibited from engaging in fraudulent activities relating to the Agreement. Further, Subcontractor is prohibited from submitting false or fraudulent statements or claims relating to the Agreement. In the event of successful prosecution of Subcontractor, Company shall take action to terminate the Agreement. (*CHIP Statement of Work Section AA.*)

3.5 Department Oversight. Upon request, Subcontractor shall make available to the Department and/or Company data, clinical and other records and reports for review of quality of care, access and utilization issues. (*CHIP Statement of Work Section DD(4).*)

3.6 Ad Hoc Reporting. The Department may require Company to submit ad hoc reports to meet a specific reporting need. These requests may result from federal or state legislative/gubernatorial data calls, requests from other state agencies, or requests from public sector entities. Subcontractor shall cooperate with Company in its reporting activities. (*CHIP Policy Manual Section 33.1.*)

4.0 REQUIREMENTS FOR COMMUNITY HEALTHCHOICES

The provisions of this Section 4 apply to any Agreement that relates to a State Contract that is a Community HealthChoices Agreement.

4.1 Compliance with HealthChoices Requirements (Section 2.0). If Subcontractor is involved in Company's Community HealthChoices program, it shall comply with the same provisions set forth in Section 2.0 (Regulatory and Contractual Requirements for HealthChoices) subject to the following:

a. Section 2.2(e) shall be replaced by a new Section 2.2(e), which shall read in its entirety as follows:

e. *Prohibition against Gag Clauses.* To the extent that Subcontractor provides medical services to Members, Subcontractor is prohibited from consenting to gag clauses which limit Subcontractor's disclosure of medically necessary or appropriate health care information or alternate therapies to Members, other healthcare professionals, or the Department. The State Contract further prohibits gag clauses which limit employees' disclosure of information pertaining to the Community HealthChoices Program. (*Community HealthChoices Agreement, Exhibit V.*)

b. Section 2.8 shall be replaced by a new Section 2.8, which shall read in its entirety as follows:

2.8 Marketing and Outreach Materials. Subcontractor shall be prohibited from distributing directly or through any agent or independent contractor, outreach materials without advance written approval of Company. Outreach materials include pamphlets and brochures to be used by an Independent

Enrollment Agency to assist Participants in choosing a CHC-MCO and PCP. (*Community HealthChoices Agreement Section V(O)(2).*)

c. Following Section 2.13, new Sections 2.14 to 2.15 are added, which shall read as follows:

2.14 Service Coordinators. Subcontractor shall comply with all Service Coordination program requirements, including, where applicable, cooperation with the Person-Centered Planning Team (PCPT) approach for Person-Centered Service Plan (PCSP) and Service Coordination. (*Community HealthChoices Draft RFP, Exhibit II).*)

2.15 Security. Subcontractor shall maintain the security of Company and/or Commonwealth data and information. This includes: compliance with all applicable federal and state laws and regulations regarding security standards; demonstration that specific controls are in place to safeguard Managed Information System and Commonwealth data and information; and demonstration of procedures for mitigating data breaches. (*Community HealthChoices Agreement Section V(O)(5)(r).*)

5.0 GENERAL TERMS AND CONDITIONS

The provisions of this Section 5 apply to any Agreement that relates to a State Contract that is a HealthChoices Agreement, an agreement for the Pennsylvania Children's Health Insurance Program, and/or a Community HealthChoices Agreement.

5.1 Americans with Disabilities Act. During the performance of the Agreement, the Subcontractor agrees as follows:

a. Subcontractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, sexual orientation, gender identity, or national origin. Subcontractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, creed, color, sex, sexual orientation, gender identity, or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Subcontractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Department setting forth the provisions of this nondiscrimination clause.
b. Subcontractor will, in all solicitations or advertisements for employees placed by or on behalf of Company, state that all qualified applicants will receive consideration for employment without regard to race, creed, color, sex, sexual orientation, gender identity, or national origin.
c. Subcontractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the Department, advising the labor union or workers' representative of Subcontractor's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, as amended by Executive Order No. 13672 of July 21, 2014, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
d. Subcontractor will comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, as amended by Executive Order No. 13672 of July 21, 2014, and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. Subcontractor will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, as amended by Executive Order No. 13672 of July 21, 2014, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the Department and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of Subcontractor's noncompliance with the nondiscrimination clauses of the Agreement or with any of such rules, regulations, or orders, the Agreement may be cancelled, terminated or suspended in whole or in part and Subcontractor may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, as amended by Executive Order No. 13672 of July 21, 2014, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, as amended by Executive Order No. 13672 of July 21, 2014, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

g. Subcontractor will include the provisions of Paragraphs (a) through (g) in every subcontract or purchase order unless exempted by rule, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of Sept. 24, 1965, as amended by Executive Order No. 13672 of July 21, 2014, so that such provisions will be binding upon each subcontractor or vendor. Subcontractor will take such action with respect to any subcontract or purchase order as the Department may direct as a means of enforcing such provisions including sanctions for noncompliance: provided, however, that in the event Subcontractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Department, Subcontractor may request the United States to enter into such litigation to protect the interests of the United States.

(Executive Order No. 11246 of Sept. 24, 1965, as amended by Executive Order No. 13672 of July 21, 2014; HealthChoices Agreement, Exhibit II; Community HealthChoices Agreement, Exhibit V.)

5.2 Non-Discrimination Clause. During the term of this Agreement, Subcontractor agrees as follows:

a. Subcontractor shall not discriminate against any employee, applicant for employment, independent contractor, or any other person because of race, color, religious creed, ancestry, national origin, age, or sex. Subcontractor shall take affirmative action to ensure that applicants are employed, and that employees or agents are treated during employment, without regard to their race, color, religious creed, ancestry, national origin, age, or sex. Such affirmative action shall include, but is not limited to, the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training. Subcontractor shall post in conspicuous places, available to employees, agents, applicants for employment and other persons, a notice to be provided by the Department.

b. Subcontractor shall in advertisements or requests for employment placed by it or on its behalf state that all qualified applicants will receive consideration for employment without regard to race, color, religious creed, ancestry, national origin, age, or sex.

c. Subcontractor shall send each labor union or workers' representative with which it has a collective bargaining agreement or other contract or understanding, a notice advising said labor union or workers' representative of its commitment to this nondiscrimination clause. Similar notice shall be sent to every other source of recruitment regularly utilized by Subcontractor.

d. It shall be no defense to a finding of a noncompliance with Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission or this nondiscrimination clause that Subcontractor had delegated some of its employment practices to any union, training program, or other source of recruitment which prevents it from meeting its obligations. However, if the evidence indicates that the Subcontractor was not on notice of the third-party discrimination or made a good faith effort to correct it, such factor shall be considered in mitigation in determining appropriate sanctions.

e. Where the practices of a union or any training program or other source of recruitment will result in the exclusion of minority group persons, so that Subcontractor will be unable to meet its obligations under the Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission or this nondiscrimination clause, Subcontractor shall then employ and fill vacancies through other nondiscriminatory employment procedures.

f. Subcontractor shall comply with the Contract Compliance Regulations of the Pennsylvania Human Relations Commission, 16 Pa. Code Chapter 49 and with all laws prohibiting discrimination in hiring or employment opportunities. In the event of Subcontractor's noncompliance with the non-discrimination clause of this contract or with any such laws, this contract may, after hearing and adjudication, be terminated or suspended, in whole or in part, and Subcontractor may be declared temporarily ineligible for further Commonwealth contracts, and such other sanctions may be imposed and remedies invoked as provided by the Contract Compliance Regulations.

g. Subcontractor shall furnish all necessary employment documents and records to, and permit access to its books, records and accounts by, the Department and the Human Relations Commission, for purposes of investigation to ascertain compliance with the provisions of the Contract Compliance Regulations, pursuant to § 49.35 (relating to information concerning compliance by contractors). If Subcontractor does not possess documents or records reflecting the necessary information requested, it shall furnish such information on reporting forms supplied by the Department or the Commission.

h. Subcontractor shall actively recruit minority subcontractors or subcontractors with substantial minority representation among their employees.

i. Subcontractor shall include the provisions of this nondiscrimination clause in every subcontract, so that such provisions will be binding upon each Subcontractor.

j. The terms used in this nondiscrimination clause shall have the same meaning as in the Contract Compliance Regulations issued by the Pennsylvania Human Relations Commission, 16 Pa. Code Chapter 49.

k. Subcontractor obligations under this clause are limited to the Subcontractor's facilities within Pennsylvania, or, where the contract is for purchase of goods manufactured outside of Pennsylvania, the facilities at which such goods are actually produced.

(*16 Pa Code 49.101; HealthChoices Agreement Section IV(C)(2); CHIP Contract at Appendix A, Section V.35-027; Commonwealth Standard terms and Conditions at 21.*)

5.3 Miscellaneous Laws Governing State Contracts. In the performance of the Agreement, the Subcontractor:

a. Shall minimize pollution and shall strictly comply with all applicable environmental laws and regulations; (*Commonwealth of Pennsylvania, Standard Grant Terms and Conditions for Services Rev. 8-29-12 at ¶4.*)

b. Shall meet the minimum percentage levels for total recycled content required by the Commonwealth for any products which are provided to the Commonwealth as a part of the performance of the Agreement; (*Commonwealth of Pennsylvania, Standard Grant Terms and Conditions for Services Rev. 8-29-12 at ¶5.*)

c. Shall permit the Company and the Commonwealth unrestricted authority to reproduce, distribute, and use any submitted report, data, or material, and any software or modifications and any associated documentation that is designed or developed and delivered to the Commonwealth as part of the performance of the Agreement; (*Commonwealth of Pennsylvania, Standard Grant Terms and Conditions for Services Rev. 8-29-12 at ¶12.*)

d. To the extent that the contract calls for services to minors, Subcontractor shall comply with the provisions of the Child Protective Services Law (Act of November 26, 1975, P.L. 438, No. 124; 23 P.S. §§ 6301-3684, as amended by Act of July 1, 1985, P.L. 124, No. 33) and all regulations promulgated thereunder (55Pa. Code, chapter 3490); (*Department of Human Services Addendum to Standard Contract Terms and Conditions, Rev. 8-16-2011 at ¶F.*)

e. Shall comply with the requirements of the Pro-Children Act of 1994; Public Law 103- 277, Part C-Environment Tobacco Smoke (also known as the Pro-Children Act of 1994) which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of healthcare services, day care, and education to children under the age of 18, if the services are funded by Federal programs whether directly or through State and Local governments (The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.); (*Department of Human Services Addendum to Standard Contract Terms and Conditions, Rev. 8-16-2011 at ¶G.*)

f. Warrants that no person or selling agency has been employed or retained to solicit or secure the Agreement upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except bona fide employees or bona fide established commercial or selling agencies maintained by the Subcontractor for the purpose of securing business. (*Commonwealth of Pennsylvania, Standard Grant Terms and Conditions for Services Rev. 8-29-12 at ¶26.*)

g. Shall not disclose to others any information, documents, reports, data, or records provided to, or prepared by, Company or Subcontractor under the Agreement without the prior written approval of the Department, except as required by the Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104, or other applicable law or as otherwise provided in the Agreement. Any information, documents, reports, data, or records secured by Company or Subcontractor from the Department or a third party in connection with the performance of the Agreement shall be kept confidential unless disclosure of such information is: (i) approved in writing by the Department prior to its disclosure; or (ii) directed by a court or other tribunal of competent jurisdiction unless the Agreement requires prior Department approval; or (iii) required for compliance with federal or state securities laws or the requirements of national securities exchanges; or (iv) necessary for purposes of Subcontractor's internal assessment and review; or (v) deemed necessary by Company or Subcontractor in any action to enforce the provisions of the Agreement or to defend or prosecute claims by or against parties other than the Department; or (vi) permitted by the valid authorization of a third party to whom the information, documents, reports, data, or records pertain: or (vii) otherwise required by law. (*Commonwealth of Pennsylvania, Standard Grant Terms and Conditions for Services Rev. 8-29-12 at ¶22(i).*)

5.4 Right to Know Law. Subcontractor understands that the State Contract and records related or arising out of the State Contract are subject to requests made pursuant to the Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104, ("RTKL").

a. If the Department and/or Company needs Subcontractor's assistance in any matter arising out of the RTKL related to the Agreement, it shall notify the Subcontractor. If the Department is the requestor, Subcontractor shall copy Company on correspondence with the Department relating to the RTKL request.

b. Upon written notification from the Department or Company that it requires Subcontractor's assistance in responding to a request under the RTKL for information related to the Agreement that may be in Subcontractor's possession constituting, or alleged to constitute, a public record in accordance with the RTKL ("Requested Information"), Subcontractor shall: (i) provide the Department and Company, within ten (10) calendar days after receipt of written notification by Department or Company, access to, and copies of, any document or information in Subcontractor's possession arising out of the Agreement that the Department reasonably believes is Requested Information and may be a public record under the RTKL; and (ii) provide such other assistance as the Department and/or Company may reasonably request, in order to comply with the RTKL with respect to the Agreement.

c. If Subcontractor considers the Requested Information to include a request for a Trade Secret or Confidential Proprietary Information, as those terms are defined by the RTKL, or other information that Subcontractor considers exempt from production under the RTKL, Subcontractor must notify the Department and Company and provide, within seven (7) calendar days of receiving the written notification, a written statement signed by a representative of Subcontractor explaining why the requested material is exempt from public disclosure under the RTKL.

d. Department and/or Company will rely upon the written statement from Subcontractor in denying a RTKL request for the Requested Information unless the Department or Company determines that the Requested Information is clearly not protected from disclosure under the RTKL. Should the Department and/or Company determine that the Requested Information is clearly not exempt from disclosure, Subcontractor shall provide the Requested Information within five (5) business days of receipt of written notification of the Requestor's determination.

e. If Subcontractor fails to provide the Requested Information within the time period required by these provisions, Subcontractor shall indemnify and hold the Department and Company harmless for any damages, penalties, costs, detriment or harm that the Department and Company may incur as a result of Subcontractor's failure, including any statutory damages assessed against the Department and Company.

f. The Department or Company will reimburse Subcontractor for any costs associated with complying with these provisions only to the extent allowed under the fee schedule established by the office of Open Records or as otherwise provided by the RTKL if the fee schedule is inapplicable.

g. Subcontractor may file a legal challenge to any Department decision to release a record to the public with the Office of Open Records, or in the Pennsylvania Courts, however, Subcontractor shall indemnify the Department for any legal expenses incurred by the Department as a result of such a challenge and shall hold the Department harmless for any damages, penalties, costs, detriment or harm that the Department may incur as a result of Subcontractor's failure, including any statutory damages assessed against the Department, regardless of the outcome of such legal challenge. As between the parties, Subcontractor agrees to waive all rights or remedies that may be available to it as a result of the Department's disclosure of Requested Information pursuant to the RTKL.

h. The Subcontractor's duties relating to the RTKL are continuing duties that survive the expiration of the Agreement and shall continue as long as the Subcontractor has Requested Information in its possession.
(*Commonwealth of Pennsylvania, Standard Grant Terms and Conditions for Services Rev. 8-29-12 at ¶ 30.*)

VIRGINIA MEDICAID COMPLIANCE ADDENDUM - SUBCONTRACTOR

This Medicaid Compliance Addendum is incorporated by reference in the Agreement. If there is any conflict between the terms of this Addendum and any of the terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, that if there is any conflict between any of the terms of the Agreement, including this Addendum, and the applicable State Contract, then the terms of the applicable State Contract will govern and control.

For purposes of this Addendum, the term "Subcontractor" shall mean a State approved entity that contracts with Company to perform part of the Company's responsibilities under the applicable State Contract. For the purposes of this Addendum and the Agreement, Subcontractor's providers shall also be considered providers of the Company. In the event that any of the following required Medicaid provisions are inapplicable to Subcontractor, as construed under the applicable State Contract and in accordance with Applicable Law, such provision shall not apply.

Company and Subcontractor agree to abide by all applicable provisions of the applicable State Contract. Subcontractor compliance with the applicable State Contract specifically includes, but is not limited to, the requirements contained herein.

1.0 DEFINITIONS

All capitalized terms used in this Addendum, and not otherwise defined in this Addendum, shall have the meanings set forth in the Agreement, or if not defined in the Agreement, in the applicable State Contract.

1.1 Applicable Law. All federal or state laws, rules, regulations, and administrative agency directives applicable to the Medicaid program and to Medicaid managed care plans, as these may be amended from time to time, including, but not limited to, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kickbacks. Applicable Laws include the Centers for Medicare and Medicaid Services' ("CMS") and the Virginia Department of Medical Assistance Services' ("DMAS" or the "Department") instructions, policy letters or guidelines that regulate the actions of Subcontractor or Company, requirements of the State Plan, as applicable, and requirements of the applicable State Contract. The "State Plan" is the State Plan for Medical Assistance, submitted to CMS by DMAS describing the nature and scope of the Virginia Medicaid program. DMAS has the authority to administer the State Plan under Code of Virginia § 32.1-325.

1.2 Medically Necessary or Medical Necessity. Appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 CFR § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. For children under age 21, medical necessity review must fully consider Federal EPSDT guidelines for Medallion 3.0 enrollees. EPSDT is not applicable to FAMIS. (*Medallion 3.0 Contract, Section 1.1; FAMIS*

Contract, Section 1.1)

2.0 REGULATORY AND CONTRACTUAL REQUIREMENTS FOR MEDALLION 3.0, FAMIS, MLTSS

The following provisions are applicable to Subcontractor to the extent that the citation following the provision references (i) a regulation of general applicability or (ii) the State Contract under which Subcontractor provides services to Company in accordance with the Agreement.

2.1 Compliance. Subcontractor agrees to maintain documentation of its compliance with 12VAC5-408 et seq., the Agreement, and any and all Applicable Laws. (*12VAC5-408-320(C)*)

2.2 Access to Facilities and Records. Subcontractor shall provide for timely and efficient access by state examiners to data, records, and personnel necessary to determine compliance with 12VAC5-408 et seq. (*12VAC5-408-320(E)*)

2.3 Subcontractor Disclosures. Subcontractor agrees to disclose the required information, at the time of application, credentialing, and/or recredentialing, in accordance with 42 CFR § 455 Subpart B and relevant provisions of the applicable State Contract, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or Federal health care programs. See 42 CFR § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs. Subcontractor shall perform, at a minimum, a monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with these Federal regulations. (*Medallion 3.0 Contract, Section 3.4.A, Section 13.3.A.I.c, and Section 13.3.A.II.c(v)-(vi); FAMIS Contract, Section 3.4.A, Section 13.3.A.I.c, and Section 13.3.A.II.c(v)-(vi); CCC Plus Contract, Section 8.4.7*)

2.4 License and Certification. Subcontractor represents and warrants that it is licensed by the Commonwealth of Virginia and has received proper certification or training to perform the specific services for which it is contracted. (*Medallion 3.0 Contract, Section 3.16; FAMIS Contract, Section 3.16; CCC Plus Contract, Section 7.1*)

2.5 Delegation Requirements.

2.5.1 Subcontractor acknowledges and agrees that the Agreement fulfills the requirements of the applicable State Contract and all Applicable Laws, including, but not limited to, the requirement to specify the activities and reporting responsibilities delegated to Subcontractor. (*Medallion 3.0 Contract, Section 3.16.A.I.b and 3.16.A.I.c; FAMIS Contract, Section 3.16.A.I.b and 3.16.A.I.c; CCC Plus Contract, Section 7.2*)

2.5.2 Subcontractor acknowledges and agrees that the Department may evaluate through inspection or other means, the quality, appropriateness, and timeliness of the services performed under the Agreement. (*Medallion 3.0 Contract, Section 3.16.A.I.d; FAMIS Contract, Section 3.16.A.I.d; CCC Plus Contract, Section 7.2*)

2.5.3 Subcontractor shall comply with Member privacy protections described in Health Insurance Portability and Accountability Act regulations and in Title 45 CFR parts 160 and 164, subparts A and E. (*Medallion 3.0 Contract, Section 3.16.A.I.e; FAMIS Contract, Section 3.16.A.I.e; CCC Plus Contract, Section 7.2*)

2.5.4 Company may revoke the delegation of services to Subcontractor under the Agreement, or impose

sanctions on Subcontractor, in the event Subcontractor's performance under the Agreement is inadequate. Subcontractor shall promptly supply to Company all information necessary for the reimbursement of any outstanding Medicaid claims. (*Medallion 3.0 Contract, Section 3.16.A.I.f; FAMIS Contract, Section 3.16.A.I.f; CCC Plus Contract, Section 7.2*)

2.6 Monitoring Requirements.

2.6.1 Subcontractor shall permit Company to perform ongoing monitoring of Subcontractor in order to assure compliance with the requirements set forth in the Agreement. (*Medallion 3.0 Contract, Section 3.16.A.II.a; FAMIS Contract, Section 3.16.A.II.a; CCC Plus Contract, Section 7.3*)

2.6.2 Subcontractor shall permit Company to perform a formal performance review of Subcontractor at least annually. (*Medallion 3.0 Contract, Section 3.16.A.II.b; FAMIS Contract, Section 3.16.A.II.b; CCC Plus Contract, Section 7.3*)

2.6.3 If applicable, Company shall monitor encounter data of Subcontractor before the data is submitted to the Department. Company shall apply certain key edits to the data to ensure accuracy and completeness. These edits shall include, but not be limited to, Member and provider identification numbers, dates of service, diagnosis and procedure codes, etc. (*Medallion 3.0 Contract, Section 3.16.A.II.c; FAMIS Contract, Section 3.16.A.II.c; CCC Plus Contract, Section 7.3*)

2.6.4 Company shall monitor Subcontractor's provider enrollment, credentialing, and re-credentialing policies and procedures to assure compliance with Federal disclosure requirements described in the applicable State Contract, with respect to disclosure of information regarding ownership and control, business transactions, and criminal convictions for crimes against Federally funded or Federally related health care programs. Additionally, Company shall monitor to assure that Subcontractor complies with requirements for prohibited affiliations with individuals or entities excluded from participating in Federal health care programs as described in the applicable State Contract. (*Medallion 3.0 Contract, Section 3.16.A.II.d; FAMIS Contract, Section 3.16.A.II.d; CCC Plus Contract, Section 7.3*)

2.6.5 As a result of monitoring activities conducted by Company (through ongoing monitoring and/or annual review), Company shall identify to Subcontractor deficiencies or areas for improvement, and Subcontractor shall take appropriate corrective action. (*Medallion 3.0 Contract, Section 3.16.A.II.e; FAMIS Contract, Section 3.16.A.II.e; CCC Plus Contract, Section 7.3*)

2.7 Review Requirements. Subcontractor acknowledges and agrees that this Addendum and the Agreement are subject to the Department's written approval. The Department may revoke such approval if the Department determines that Subcontractor fails to meet the requirements of the applicable State Contract. If Subcontractor is responsible for the provision of covered services, for the purposes of the applicable State Contract, Subcontractor shall be considered both a subcontractor and network provider. Company shall adhere to subcontractor specific restrictions set forth in the applicable State Contract. (*Medallion 3.0 Contract, Section 3.16.B; FAMIS Contract, Section 3.16.B; CCC Plus Contract, Section 7.1*)

2.8 Utilization Management.

2.8.1 If Company has delegated responsibilities for utilization management to Subcontractor, Subcontractor is prohibited from providing compensation to utilization management staff in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member. (*Medallion 3.0 Contract, Section 7.1.P; FAMIS Contract, Section 7.1.P; CCC Plus Contract, Section 6.2.12*)

2.8.2 If Company has delegated responsibilities for utilization management to Subcontractor, Subcontractor shall comply with all standards for utilization management as set forth in the applicable State Contract. Subcontractor acknowledges and agrees that the preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. (*Medallion 3.0 Contract, Section 7.1.P.II; FAMIS Contract, Section 7.1.P.II; CCC Plus Contract, Section 6.1*)

2.9 Subcontractor Cooperation with Company Programs. Subcontractor agrees to cooperate with the External Quality Review Organization (EQRO), which is contracted by the Department to perform quality studies. The level of cooperation includes, but is not limited to, responding favorably and promptly to requests for Members' medical records in the format and timeframe requested by the EQRO or the Department. (*Medallion 3.0 Contract, Section 8.4; FAMIS Contract, Section 8.4*)

2.10 Audits. Company has the right to conduct routine and random audits of Subcontractor. (*Medallion 3.0 Contract, Section 9.2.G.II; FAMIS Contract, Section 9.2.G.IV; CCC Plus Contract, Section 14.8.2*)

2.11 Hold Harmless. Subcontractor hereby agrees that in no event, including, but not limited to, nonpayment by Company or Subcontractor; the insolvency of Company; or breach of the Agreement, shall Subcontractor bill, charge, collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against Members or persons other than Company for services provided pursuant to the applicable State Contract. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of the applicable Plan. Subcontractor further agrees that (i) this provision shall survive the termination of the Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Plan's Members and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Subcontractor and any Member or other person acting on Member's behalf. The restrictions on billing Members as set forth herein and in the Agreement shall continue to be in effect even if Company becomes insolvent. Notwithstanding the foregoing, if a Member agrees in advance of receiving a service and in writing to pay for a service that is not a State Plan Covered Service, then Company, directly or through Subcontractor, can bill the Member for the service. (*Virginia Code § 38.2-5805(C)(9) and (10); 14VAC5-211-30(C); Medallion 3.0 Contract, Section 12.9 and Attachment III; FAMIS Contract, Section 12.9 and Attachment III, Section A.13*)

2.12 Billing Members for Medically Necessary Services.

2.12.1 Subcontractor is subject to criminal penalties if providers knowingly and willfully charge, for any service provided to a Member under the State Plan or under the applicable State Contract, money or other consideration at a rate in excess of the rate established by the Department, as specified in Section 1128B (d)(1) of the Social Security Act (42 U.S.C. § 1320a-7b), as amended. This provision shall continue to be in effect even if Company or Subcontractor becomes insolvent until such time as Members are withdrawn from assignment to Company. (*Medallion 3.0 Contract, Section 12.9.A; FAMIS Contract, Section 12.9.A; CCC Plus Contract, Section 11.7*)

2.12.2 Pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), Subcontractor shall not hold a Member liable for (i) debts of Company in the event of Company's insolvency; (ii) payment for services provided by Company if Company has not received payment from the Department for the services or if the provider, under contract or other arrangement with Company, fails to receive payment from the Department or Company; (iii) payments to providers that furnish covered services under a contract or other arrangement with Company that are in excess of the amount that normally would be paid by Member if the service had been received directly from Company. In addition, for CCC Plus Members only, Subcontractor shall not hold a CCC Plus Member liable for payments in excess of the contracted amount or coinsurance, copayments, deductibles, financial penalties, or any other amount other than any Patient Pay established by DSS towards LTSS services. (*Medallion 3.0 Contract, Section 12.9.A.I, II, and III; FAMIS Contract, Section 12.9.A.I, II, and III; CCC Plus Contract, Section 11.7*)

2.13 Bonuses and Incentive Payments. Company shall not provide bonus and/or incentive payments to Subcontractor which are determined based upon the applicability of the contract provision specified in Section 12.11 of the applicable State Contract. (*Medallion 3.0 Contract, Section 12.11; FAMIS Contract, Section 12.11*)

2.14 Prohibited Actions.

2.14.1 Subcontractor may not knowingly have a relationship of a type described in Section 2.14.2 with (i) an individual or entity who is debarred, suspended, or otherwise excluded from participating in Federal health care programs, as listed on the federal List of Excluded Individuals/ Entities (LEIE) database at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued

under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or (ii) an individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in clause (i). Subcontractor is further prohibited from contracting with providers who have been terminated from the Medicaid or FAMIS programs by DMAS for fraud, waste and abuse. (*Medallion 3.0 Contract, Section 13.3.A.I.a(i) and (ii) and 13.3.C.I; FAMIS Contract, Section 13.3.A.I.a(i) and (ii) and Section 13.3.C.I*)

2.14.2 The relationships described in this section are as follows: (i) a director, officer, or partner of the Company; (ii) a person with beneficial ownership of five percent or more of Company's equity; or (iii) a person with an employment, consulting or other arrangement with Company for the provision of items and services that are significant and material to Company's obligations under the applicable State Contract with the Department. (*Medallion 3.0 Contract, Section 13.3.A.I.b(i), (ii), and (iii); FAMIS Contract, Section 13.3.A.I.b(i), (ii), and (iii)*)

2.14.3 Subcontractor shall immediately report to Company any exclusion information discovered on the LEIE database (or any other database). (*Medallion 3.0 Contract, Section 13.3.C.II; FAMIS Contract, Section 13.3.C.II; CCC Plus Contract, Section 8.4.7*)

2.14.4 Subcontractor shall maintain written policies and procedures outlining provider enrollment and/or credentialing process. (*Medallion 3.0 Contract, Section 13.3.C.II; FAMIS Contract, Section 13.3.C.II*)

2.15 Protected Health Information. If Subcontractor receives or has access to protected health information ("PHI"), Subcontractor shall sign an agreement with Company that complies with the Health Insurance Portability and Accountability Act, and Subcontractor agrees to be bound by the restrictions, terms, and conditions relating to PHI that apply to Company in the applicable State Contract. (*Medallion 3.0 Contract, Section 13.5.A, 13.5.B, 13.5.B.III, and 14.19.B; FAMIS Contract, Section 13.5A, 13.5.B, 13.5.B.III, and 14.19.B; CCC Plus Contract, Sections 16.11.4 and 16.11.5*)

2.16 Access to Facilities and Records. Subcontractor shall allow duly authorized agents or representatives of the State or Federal Government, including, but not limited to, the Department, during normal business hours, access to its premises to inspect, audit, monitor or otherwise evaluate the performance of Subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested, Subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Subcontractor's activities. All information so obtained will be accorded confidential treatment as provided under Applicable Law. The Department and its duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of Subcontractor and shall be allowed to inspect, copy, and audit any medical and/or financial records of Subcontractor. (*Medallion 3.0 Contract, Section 14.1 and 14.19.B.I; FAMIS Contract, Section 14.1 and 14.19.B.I.*)

2.17 Worker's Compensation. Subcontractor shall obtain and maintain, for the duration of this Agreement, workers' compensation insurance for all its employees working in the Commonwealth. (*Medallion 3.0 Contract, Section 14.16.B; FAMIS Contract, Section 14.16.B*)

2.18 Medical Records. Subcontractor shall comply with the security and confidentiality of records standards as detailed in the applicable State Contract. (*Medallion 3.0 Contract, Section 14.19; FAMIS Contract, Section 14.19*)

2.19 Subcontractor Bankruptcy. Subcontractor shall notify Company of any bankruptcy filing on or before the date of such filing. (*Medallion 3.0 Contract, Section 14.29.B.VI; FAMIS Contract, Section 14.29.B.VI; CCC Plus Contract, Section 21.3.3*)

3.0 STATUTORY AND REGULATORY REQUIREMENTS FOR MANAGED CARE PLANS

3.1 Termination. If Subcontractor terminates the Agreement, Subcontractor shall give Company at least 60 days' advance notice of termination. In addition, Subcontractor shall ensure that any agreement to provide health care services between Subcontractor and a health care provider requires the provider to give at least 60 days' advance notice of termination of such agreement to Subcontractor. (*Virginia Code § 38.2-5805(C)(6) and (C)(7)*)

4.0 REGULATORY REQUIREMENTS SPECIFIC TO MEDALLION 3.0 MANAGED CARE PLANS

4.1 Requests for Service. Subcontractor shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of service, when applicable under the Agreement. (*12VAC30-120-380(H)*)

5.0 COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) CONTRACT REQUIREMENTS FOR MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS)

5.1 General Requirements: (*CCC Plus Contract, Section 7.1*)

5.1.1 Company may utilize subcontracts with third-party administrators for the purpose of processing claims and other purely administrative functions. To the extent that Subcontractor is a third-party administrator, Subcontractor shall provide services in accordance with the level and quality of care requirements under the CCC Plus Contract.

5.1.2 Subcontractor shall have proper certification or training to perform the specific services for which Subcontractor is contracted.

5.1.3 The Agreement is subject to the Department's written approval. The Department may revoke such approval if the Department determines that Subcontractor fails to meet the requirements of the CCC Plus Contract.

5.1.4 To the extent that Subcontractor is responsible for providing Covered Services, Subcontractor shall comply with the terms set forth in the CCC Plus Reporting Manual.

5.1.5 Subcontractor agrees that all service level agreements with the Department will be met or exceeded.

5.1.6 To the extent that Subcontractor performs functions on Company's behalf, or to the extent that Subcontractor subcontracts with any individual or entity who performs functions on Company's or Subcontractor's behalf, Subcontract shall, and shall ensure that its subcontractors, comply with the terms of the CCC Plus Contract and the requirements set forth at 42 CFR § 438.3 and 438.230. In addition, all of Subcontractor's subcontracts with individuals or entities performing functions on Company's or Subcontractor's behalf shall meet the delegation and monitoring requirements set forth in this Addendum and in the CCC Plus Contract and are subject to audit by the Department.

5.2 Additional Delegation Requirements – CCC Plus: (*CCC Plus Contract, Section 7.2*)

5.2.1 Subcontractor shall ensure that any contracts or agreements with subcontractors performing functions on Company's or Subcontractor's behalf are in writing.

5.2.2 Subcontractor shall require its provider contracts to comply with all provider provisions of the CCC Plus Contract and applicable Federal and State laws and regulations.

5.2.3 Subcontractor acknowledges and agrees that the State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Subcontractor and the Subcontractor's subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

5.3 Additional Monitoring Requirements – CCC Plus. Company shall perform an annual review on Subcontractor to assure that the health care professionals under contract with Subcontractor are qualified to perform the services covered under the CCC Plus Contract. (*CCC Plus Contract, Section 7.3*)

5.4 Protecting Member from Liability for Payment. Subcontractor shall not deny any service covered under the CCC Plus Contract to a Member for failure or inability to pay any applicable charge or where Member, who, prior to becoming CCC Plus program eligible, incurred a bill that has not been paid. (*CCC Plus Contract, Section 11.7*)

5.5 Fraud and Abuse. Subcontractor shall immediately report all incidents of potential or actual fraud, waste, and abuse to Company and to the Department. (*CCC Plus Contract, Section 14.10*)

5.6 Medically Necessary or Medical Necessity. Per Virginia Medicaid, Medically Necessary or Medical Necessity is defined as an item or service provided for the diagnosis or treatment of an enrollee's condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those under age 21) and Federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230. (*CCC Plus Contract, Section 23.1*)

5.7 HIPAA Compliance. Subcontractor shall comply with all State and Federal laws and regulations with regards to handling, processing, or using the Department's PHI and ePHI. This includes, but is not limited to, 45 CFR Parts 160 and 164 Modification to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule, January 25, 2013 and related regulations as they pertain to the Agreement. (*CCC Plus Contract, Section 2.7*)

5.8 Excluded Entities/Service Providers. Subcontractor shall not knowingly have an employment, consulting, provider agreement, or other agreement or relationship for the provision of items and services that are significant and material to the Subcontractor's obligations under the applicable State Contract with any person, or affiliate of such person, who is excluded, under Federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five (5) percent of Subcontractor's equity or be permitted to serve as a director, officer, or partner of Subcontractor. Subcontractor is further prohibited from contracting with providers who have been terminated from the Medicaid program by DMAS for fraud, waste and abuse. Subcontractor shall conduct monthly checks to screen providers for exclusion, using the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Aware Management (SAM), and any other databases as the State may prescribe. The Federal Health and Human Services – Office of Inspector General maintains an online exclusions database available at http://exclusions.oig.hhs.gov/. Subcontractor shall consult these databases upon contracting with providers and no less frequently than monthly thereafter. (*CCC Plus Contract, Sections 2.11 and 8.4.7*)

5.9 Conflict of Interest. For the duration of the CCC Plus Contract, Subcontractor shall not have any interest that will conflict, as determined by DMAS, with the performance of services under the CCC Plus Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, Subcontractor shall not have any financial, legal, contractual, or other business interest in any entity performing CCC Plus program enrollment functions for DMAS or Related Entity(ies), if any. (*CCC Plus Contract, Section 22.7*)

5.10 Drug-Free Workplace. To the extent that the Agreement is for more than $10,000, Subcontractor agrees that, during the performance of the Agreement, Subcontractor shall: (i) provide a drug-free workplace for Subcontractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in Subcontractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of Subcontractor that the Business Associate maintains a drug-free workplace. For purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with the CCC Plus Contract, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the CCC Plus Contract. (*CCC Plus Contract, Section 22.23*)

5.11 Notification Obligations to Company and DMAS. Subcontractor shall notify Company within sixty (60) days of any changes to a provider or subcontractor agreement regarding termination, pending termination, or pending modification in the subcontractor's or provider's terms that could reduce Member access to care. *(CCC Plus Contract, Section 8.5.6)*

Exhibit B-9

Regulatory Compliance Addendum

Governing Illinois Medicaid Services

This Regulatory Compliance Addendum Governing Illinois Medicaid Services (the "Illinois Medicaid Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under, as well as the provision of any administrative or health-benefit management services/functions that relate to, as applicable:

(3) the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health Inc., an Illinois Corporation, for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization*, Contract No. 2015-24-004 (ABH) f/k/a Contract No. 2010-24-005-K, effective on or about May 1, 2011, which governs the program known as the Illinois Integrated Care Program a/k/a the ICP (the "ICP Contract");

(4) the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health for Furnishing Health Services by a Managed Care Organization*, Contract No. 2015-24-002, effective on or about August 1, 2014, which governs the program known as the Illinois Family Health Plan Population–Affordable Care Act Adult program a/k/a FHP-ACA program (the "FHP-ACA Contract"); and/or

(5) the *State of Illinois Contract Between the Department of Healthcare and Family Services and Aetna Better Health Inc., an Illinois Corporation for Furnishing Managed Long Term Supports and Services by a Managed Care Organization*, Contract No. 2017-24-002-K, effective on or about July 1, 2016, which governs the program known as the Illinois Managed Long Term Supports and Services a/k/a MLTSS program (the "MLTSS Contract").

Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois ("Company") serves as a managed-care organization under the ICP Contract, the FHP-ACA Contract, and the MLTSS Contract (the "State Contracts") on behalf of the State of Illinois and its Department for Healthcare and Family Services ("HFS" and collectively, the "State").

The State requires that specific terms and conditions be incorporated into the Agreement. As such, this Illinois Medicaid Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof), and such provider, vendor, contractor, or other entity must comply with the requirements set forth herein to the extent applicable to the services provided by vendor under the Agreement. Note that this Illinois Medicaid Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in the policies, procedures, and provider manual of Company (or its Affiliate, as the case may be). This Illinois Medicaid Addendum and the Agreement may be revised as directed by the State.

For purposes of this Illinois Medicaid Addendum, the individuals who are enrolled with Company under the State Contracts will be referred to as the "Enrollees." All capitalized terms not defined in this Illinois Medicaid Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Illinois Medicaid Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Illinois Medicaid Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contracts and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contracts. Except as provided herein, all other provisions of the Agreement not inconsistent with this Illinois Medicaid Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Illinois Medicaid Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The provider, vendor, contractor, or other entity identified on the first page of the Agreement represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Illinois Medicaid Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

I. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this Illinois Medicaid Addendum:

a. "Authorized Persons" – Collectively means HFS, HFS's Office of Inspector General ("HFS OIG"), the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, the United States Department of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS"), and any other State or federal agencies with monitoring authority related to Medicaid. [ICP Contract § 1.19; FHP-ACA Contract § 1.20; MLTSS Contract § 1.18]

b. "Provider" – Means any individual or entity that is enrolled with the State to provide Covered Services to Enrollees and that is associated with Company pursuant to a written contract or agreement for the purpose of providing health care services under the State Contracts. [ICP Contract §§ 1.16, 1.118; FHP-ACA Contract §§ 1.16, 1.17, 1.122; MLTSS Contract §§ 1.14, 1.15, 1.125]

c. "Subcontractor" – Means any individual or entity, other than a Provider, with which Company has entered into a written agreement for the purpose of delegating responsibilities applicable to Company under the State Contracts. [ICP Contract § 1.144; FHP-ACA Contract § 1.148; MLTSS Contract § 1.150]

J. Requirements Applicable to State Contracts and Covered Services

1. Practice Coverage and Hours; Enrollee Appointments. Provider agrees to provide Covered Services to Enrollees as set forth in the Agreement, including without limitation the following when such Covered Services are specified in the Agreement:

a. Primary care providers (PCPs) and specialty Providers shall provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after-hours telephone number (after-hours voicemail alone is not acceptable). [ICP Contract § 5.6.4; FHP-ACA Contract § 5.7.4]

b. Provider shall offer to Enrollees hours of operation that are no less than the hours of operation offered to persons who are not Enrollees. [ICP Contract § 5.6.3; FHP-ACA Contract § 5.7.3; MLTSS Contract § 5.6.3]

c. Provider shall ensure that time-specific appointments for routine, preventive care to an Enrollee are available within five (5) weeks from the date of request for such care, and within two (2) weeks from the date of request for infants under age six (6) months. If an Enrollee has more serious problems that are not deemed emergency medical conditions, Provider shall triage that Enrollee and, if necessary or appropriate, immediately refer that Enrollee for urgent medically necessary care or provide that Enrollee with an appointment within one (1) business day of the request. If an Enrollee has a problem or complaint that is not deemed serious, Provider shall see that Enrollee within three (3) weeks from the date of request for such care. If Enrollee seeks an initial prenatal visit without expressed problems, the Provider shall see that Enrollee within two (2) weeks after a request if the Enrollee is in her first trimester, within one (1) week if the Enrollee is in her second trimester, and within three (3) days if the Enrollee is in her third trimester. [ICP Contract § 5.6.3; FHP-ACA Contract § 5.7.3; MLTSS Contract § 5.6.3]

2. Payments; Hold Harmless of Enrollees/State.

a. Provider/Subcontractor acknowledges and agrees that Company shall not pay a Provider/Subcontractor for any provider-preventable condition. Provider/Subcontractor shall report all provider-preventable conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made. [FHP-ACA Contract § 5.25.8; MLTSS Contract § 5.24.8]

b. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state plan or waiver. [42 U.S.C. § 1396a(a)(80); 42 C.F.R. § 438.602(i)]

c. Provider/Subcontractor acknowledges and agrees that upon CMS's implementation of Section 1861(o)(7) of the Social Security Act, Company is prohibited by applicable federal law from making payments for services or items (other than an emergency service or item furnished in an emergency room of a hospital) for home health care services provided by an agency or organization unless that agency or organization has provided the State with a surety bond as specified in Section 1861(o)(7) of the Social Security Act. [MLTSS Contract § 5.5.1.4]

d. Except as permitted or required by HFS in 89 Ill. Adm. Code 125, in HFS's fee-for-service copayment policy in effect at the time Covered Services are provided, and/or in the State Contracts, neither Company nor Provider/Subcontractor may seek or obtain funding through fees or charges to any Enrollee receiving Covered Services under the State Contracts. Provider/Subcontractor furthermore acknowledges and agrees that imposing charges in excess of those permitted under the State Contracts is a violation of Section 1128B(d) of the Social Security Act and subjects the party imposing such charges to criminal penalties. [ICP Contract § 5.30; FHP-ACA Contract § 5.30; MLTSS Contract § 5.29]

e. Provider/Subcontractor agrees that in no event, including but not limited to the nonpayment by Company of amounts due to Provider/Subcontractor under the Agreement, the insolvency of Company, or any breach of the Agreement by Company, shall Provider/Subcontractor or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against the Enrollee or persons acting on the Enrollee's behalf (other than Company) for services provided pursuant to the Agreement except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Enrollees and all persons acting on the Enrollees' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider/Subcontractor and the Enrollee or persons acting on the Enrollee's behalf (other than Company). [215 ILCS 125/2-8(a)]

f. Any dispute between Company and Provider/Subcontractor shall be solely between those parties, and Company and Provider/Subcontractor shall each hold harmless the State and its agencies, officers, employees, agents, and volunteers from and against such dispute and any and all liabilities, demands, claims, suits, losses, damages, causes of action, fines, or judgments, including costs, attorneys' and witnesses' fees, and expenses incident thereto, regardless of the reason. [ICP Contract §§ 7.13, 9.1.8, 9.1.28; FHP-ACA Contract §§ 7.13, 9.1.8, 9.1.28; MLTSS Contract §§ 7.13, 9.1.8, 9.1.28]

3. Standards of Care. In addition to complying with other applicable standards of care, Provider/Subcontractor shall:

a. Timely identify any Enrollees with high-risk pregnancies and arrange for a maternal fetal medicine specialist or a transfer to Level III perinatal facilities in accordance with ACOG guidelines and the Illinois Perinatal Act requirements for referral and/or transfer of high-risk women. [ICP Contract, Attachment XXI ¶ 3.c.i.D; FHP-ACA Contract, Attachment XXI ¶ 3.c.i.D; MLTSS Contract, Attachment XXI ¶ 3.c.i.D]

b. Cooperate and communicate with other service providers who serve Enrollees, including without limitation Special Supplemental Nutrition Programs for Women, Infants, and Children (commonly referred to as "WIC" programs); Head Start programs; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the Enrollee). [ICP Contract, Attachment XXI ¶ 3.e.i.; FHP-ACA Contract, Attachment XXI ¶ 3.e.i.; MLTSS Contract, Attachment XXI ¶ 3.e.i.]

4. Cultural Competence; Prohibition on Discrimination. In addition to complying with other applicable standards:

a. Provider/Subcontractor shall cooperate in the implementation of, and comply with all requirements set forth in, Company's Cultural Competence Plan, which shall include implementation of the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). Provider/Subcontractor acknowledges and agrees that all Covered Services shall be provided in a culturally competent manner by ensuring the cultural competence of all Provider/Subcontractor staff, from clerical to executive management. Furthermore, Subcontractors shall complete Company's initial and annual cultural-competence training. [ICP Contract §§ 2.7, 2.7.3, 2.7.4; FHP-ACA Contract §§ 2.7, 2.7.3, 2.7.4; MLTSS Contract §§ 2.7, 2.7.3, 2.7.4]

b. Provider/Subcontractor shall abide by all federal and State laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Illinois Human Rights Act, and Executive Orders 11246 and 11375. Provider/Subcontractor furthermore agrees to take affirmative action to

ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Agreement. Provider/Subcontractor will furthermore not discriminate against Enrollees or prospective or potential Enrollees on the basis of health status, need for health services, or payment source. All Provider/Subcontractor locations where Enrollees receive Covered Services shall comply with the Americans with Disabilities Act of 1990. [77 Ill. Admin. Code § 240.50(d)(4); ICP Contract §§ 2.8, 5.6.2, 9.1.22; FHP-ACA Contract §§ 2.8, 5.7.2, 9.1.22; MLTSS Contract §§ 2.8, 5.6.2, 9.1.22]

5. Anti-Gag Clause; Prohibition on Retaliation. Provider/Subcontractor shall not be prohibited or otherwise restricted or discouraged from, and shall not prohibit or otherwise restrict or discourage its downstream providers or subcontractors from, taking any of the following actions so long as those actions are within the lawful scope of the acting party's practice: (a) advocating for medically appropriate health care services for Enrollees, which may include without limitation appealing denials and protesting decisions, policies, and practices; (b) advising an Enrollee about the health status of that Enrollee or medical care or treatment for that Enrollee's condition or disease regardless of whether benefits for such care or treatment are provided under the Agreement and/or the State Contracts; and/or (c) discussing with Enrollees, prospective Enrollees, or the public any health care services, health care providers, utilization review policies, quality assurance policies, or terms and conditions of plans and plan policy. Furthermore, Company shall not retaliate against Provider/Subcontractor, and Provider/Subcontractor shall not retaliate against its downstream providers or subcontractors, for any of the foregoing actions. Notwithstanding the foregoing, nothing in this provision shall be construed to prohibit: (a) Company or Provider/Subcontractor from making a determination not to pay for a particular health care service, from enforcing reasonable peer review or utilization review protocols, or from determining whether a physician or other health care provider has complied with those protocols; and/or (b) a Provider that is a hospital from taking disciplinary actions against a physician as authorized by law. [215 ILCS 134/30(a); 215 ILCS 134/35(a)–(d); ICP Contract § 5.32; FHP-ACA Contract § 5.32; MLTSS Contract § 5.31]

6. Grievances and Appeals. Provider/Subcontractor shall comply with Company's grievance and appeal processes referenced in the Agreement, and Company shall notify Provider/Subcontractor within fifteen (15) days following any substantive change to such procedures. [ICP Contract § 5.28.6; FHP-ACA Contract § 5.28.6; MLTSS Contract § 5.27.6]

7. Data and Reporting.

a. Provider/Subcontractor shall submit all data, reports, and clinical information required by Company under the State Contracts in such manner and format, and pursuant to such timeframes, as requested by Company and/or HFS. Provider/Subcontractor shall ensure that all data and reports that it submits to Company are accurate and complete, and Provider/Subcontractor furthermore acknowledges and agrees that all such data and reports shall be available to HFS and, upon request, to federal CMS. [ICP Contract § 5.24; FHP-ACA Contract § 5.24; MLTSS Contract § 5.23]

b. If Provider/Subcontractor provides Covered Services to Enrollees under a Illinois Department of Human Services ("DHS") Home and Community-Based Services ("HCBS") Waiver, under the Medicaid Clinic Option, or under the Medicaid Rehabilitation Option, or provides subacute alcoholism and substance-abuse treatment services pursuant to 89 Ill. Admin. Code §§ 148.340–148.390 and 77 Ill. Admin. Code Part 2090, such Provider/Subcontractor shall enter any data regarding Enrollees that is required under State rules, or under a contract between the Provider/Subcontractor and DHS, into any subsystem maintained by DHS, including, but not limited to, DHS's Automated Reporting and Tracking System (DARTS). [FHP-ACA Contract § 5.28.1.3; MLTSS Contract § 5.27.1.3]

8. Delegation. If Company delegates to Provider/Subcontractor any activities or obligations under the State Contracts:

a. Company shall remain ultimately responsible for the performance of those responsibilities and nothing in the Agreement shall be construed to terminate Company's legal responsibility to DHS to assure that all activities under the State Contracts are carried out. [ICP Contract §§ 5.28.2, 5.28.3; FHP-ACA Contract §§ 5.28.2, 5.28.3; MLTSS Contract §§ 5.27.2, 5.27.3]

b. Provider/Subcontractor acknowledges and agrees that Company's delegated oversight committee will oversee Provider/Subcontractor's activities and performance under the Agreement to ensure compliance with all applicable contractual and statutory requirements, including without limitation the Illinois Human Rights Act, the U.S. Civil Rights Act, and Section 504 of the federal Rehabilitation Act. Company's oversight of Provider/Subcontractor will include, without limitation: pre-delegation audits; quarterly delegation oversight reviews of delegate performance; monthly joint-operation meetings; annual audits of Provider/Subcontractor; regular monitoring of Enrollee complaints with respect to Provider/Subcontractor; and documentation of issues and development of a corrective action plan, as warranted, to improve performance. [ICP Contract § 2.7.4; FHP-ACA Contract § 2.7.4; MLTSS Contract § 2.7.4]

c. To the extent that such delegated activities are credentialing or recredentialing activities or obligations under the State Contracts, Provider/Subcontractor shall maintain a formal credentialing program and shall conduct all such activities or obligations in compliance with Company, National Committee for Quality Assurance (NCQA), and State standards. Company shall monitor such credentialing/recredentialing delegated activities and shall review Provider/Subcontractor's credentialing files no less than annually as part of the annual audit. [ICP Contract § 5.7.4, Attachment XI ¶ 7.e.; FHP-ACA Contract § 5.8.4, Attachment XI ¶ 7.e.; MLTSS Contract § 5.7.4, Attachment XI ¶ 7.e.]

9. Offshore Services. Provider/Subcontractor is prohibited from using any individual or entity (an "Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative, or other individual or entity) to perform any services for Company 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/Subcontractor further agrees that Company has the right to audit any Offshore Entity prior to the provision of Offshore Services for Company. Provider/Subcontractor further represents and warrants that it does not and will not permit any Enrollee's protected health information (PHI) or other personal information to be accessible by any Offshore Entity, without prior written notice to Company and Company's prior written approval of such Offshore Entity. In the event that Company agrees in advance and in writing to permit Provider/Subcontractor to use an Offshore Entity to perform any services for Company and Company agrees that such Offshore Entity will receive, process, transfer, handle, store, or access Enrollee PHI as defined at 45 C.F.R. § 160.103, Provider/Subcontractor agrees that Offshore Services that involve Enrollee Member PHI may be subject to mandatory reporting to CMS and/or other applicable government regulators. [MLTSS Contract § 5.27.14]

10. Quality Assurance. With respect to Company's quality-assurance obligations under the State Contracts:

a. Provider/Subcontractor shall participate in and cooperate with Company's quality-assurance program (QAP), shall cooperate with Company with respect to Company's QAP obligations under the State Contracts, and shall cooperate with Company's quality improvement committee. Provider/Subcontractor shall furthermore allow Company to access Provider/Subcontractor's Enrollee medical records to permit effective quality review and monitoring of Provider/Subcontractor's compliance with policies and procedures, specifications, and appropriateness of care, and such access shall include the right of Company to make and/or obtain a copy (in either electronic or hardcopy form) of such records. [ICP Contract, Attachment XI ¶ 6.b.; FHP-ACA Contract, Attachment XI ¶ 6.b.; MLTSS Contract, Attachment XI ¶¶ 2.b.ii., 6.b.]

b. Provider/Subcontractor shall provide, arrange for, or participate in the quality-assurance programs mandated by the Illinois Health Maintenance Organization Act, unless the Illinois Department of

Public Health has certified that such programs will be fully implemented without any participation or action from Provider/Subcontractor. [215 ILCS 125/2-8(a); 50 Ill. Admin. Code § 5241.50(a)(4)]

c. Provider/Subcontractor acknowledges and agrees that Company shall perform quality-assurance evaluations of Provider/Subcontractor's practices, which shall include monitoring of Enrollee accessibility to ensure linguistic and physical accessibility. [ICP Contract § 2.7.5; FHP-ACA Contract § 2.7.5; MLTSS Contract § 2.7.5]

d. Provider/Subcontractor shall cooperate and comply with all remedial or corrective actions that Company implements with respect to Provider/Subcontractor and/or its services under the Agreement, upon Company's determination that Provider/Subcontractor has furnished inappropriate or substandard services or has failed to furnish services that should have been furnished. [ICP Contract, Attachment XI ¶ 3.e.; FHP-ACA Contract, Attachment XI ¶ 3.e.; MLTSS Contract, Attachment XI ¶ 3.e.]

e. If Company delegates to Provider/Subcontractor any quality-assurance activities or obligations that Company has under the State Contracts:

Company and Provider/Subcontractor shall agree in writing upon the delegated activities, the accountability of Provider/Subcontractor for those activities, and the frequency of Provider/Subcontractor's reporting to Company related to those activities. [ICP Contract, Attachment XI ¶ 7.a.; FHP-ACA Contract, Attachment XI ¶ 7.a.; MLTSS Contract, Attachment XI ¶ 7.a.]

Company and Provider/Subcontractor shall agree in writing upon the standards and procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided. [ICP Contract, Attachment XI ¶ 7.b.; FHP-ACA Contract, Attachment XI ¶ 7.b.; MLTSS Contract, Attachment XI ¶ 7.b.]

All such delegated activities shall conform to the requirements set forth in the State Contracts. [ICP Contract, Attachment XI ¶ 7.c.; FHP-ACA Contract, Attachment XI ¶ 7.c.; MLTSS Contract, Attachment XI ¶ 7.c.]

Provider/Subcontractor acknowledges and agrees that Company shall engage in continuous and ongoing evaluation and oversight of such delegated activities, including approval of quality-improvement plans and regular specified reports, as well as a formal review of such activities. Company's oversight of Provider/Subcontractor's performance of these delegated activities must include no less than an annual audit, analyses of required reports and encounter data, a review of Enrollee complaints, grievances, Provider complaints, and quality of care concerns raised through encounter data, monitoring activities, or other venues. Outcomes of Company's annual audit shall be submitted to HFS as part of Company's QA/UR/PR Annual Report. [ICP Contract, Attachment XI ¶ 7.d.; FHP-ACA Contract, Attachment XI ¶ 7.d.; MLTSS Contract, Attachment XI ¶ 7.d.]

If Company or Provider/Subcontractor identifies areas requiring improvement, Company or Provider/Subcontractor, as appropriate, shall take corrective action and implement a quality improvement initiative. If one or more deficiencies are identified, Provider/Subcontractor must develop and implement a corrective action plan, with protections put in place by Company to prevent such deficiencies from recurring. Evidence of ongoing monitoring of the delegated activities sufficient to assure corrective action shall be provided to HFS through quarterly or annual reporting. [ICP Contract, Attachment XI ¶ 7.f.; FHP-ACA Contract, Attachment XI ¶ 7.f.; MLTSS Contract, Attachment XI ¶ 7.f.]

11. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy-related Covered Services under the ICP Contract and FHP-ACA Contract:

a. Provider/Subcontractor shall administer all pharmacy benefits in accordance with the provisions and requirements of the State Contracts and all applicable State and federal laws and regulations. [ICP Contract §§ 5.1.7, 5.16.6; FHP-ACA Contract §§ 5.2.5, 5.16.6]

b. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contracts to submit required pharmacy-related reports and data to applicable federal and State authorities. [ICP Contract, Attachment XIII; FHP-ACA Contract, Attachment XIII]

c. If Company delegates to Provider/Subcontractor any pharmacy-related activities or obligations that Company has under the State Contracts, Provider/Subcontractor shall comply with all pharmacy-related provisions and requirements set forth in the State Contracts, including without limitation the following, as applicable:

(i) Company and Provider/Subcontractor shall submit a pharmacy formulary for prior approval by the State initially and annually thereafter. [ICP Contract § 5.1.7; FHP-ACA Contract § 5.2.5]

(ii) Company and Provider/Subcontractor shall provide coverage of drugs in all classes of drugs for which HFS's fee-for-service program provides coverage. [ICP Contract § 5.1.7.1; FHP-ACA Contract § 5.2.5.1]

(iii) Company and Provider/Subcontractor shall cover only drugs made by manufacturers that participate in the federal Medicaid drug rebate program, which applies to both prescription and over-the-counter drugs, but does not apply to non-drug items such as blood sugar test strips. HFS will provide a listing of manufacturers that participate in the federal Medicaid drug rebate program. [ICP Contract § 5.1.7.2; FHP-ACA Contract § 5.2.5.2]

(iv) Company and Provider/Subcontractor may determine their own utilization controls, including without limitation step therapy and prior approval, unless otherwise prohibited under the State Contracts, to ensure appropriate utilization. Company and Provider/Subcontractor shall utilize HFS's step-therapy and prior-authorization requirements for family-planning drugs and devices as set forth in the State Contracts. [ICP Contract § 5.1.7.3; FHP-ACA Contract § 5.2.5.3]

(v) Company and Provider/Subcontractor shall ensure that they require pharmacy, medical, and hospital providers to identify 340B-purchased drugs on pharmacy, medical, and hospital claims following HFS billing guidelines applied in HFS's fee-for-service program, and Company and Provider/Subcontractor shall furthermore ensure that its encounter claims to HFS identify these drugs. [ICP Contract § 5.1.7.4; FHP-ACA Contract § 5.2.5.4] For any outpatient drugs *not* identified in accordance with the previous sentence: (i) Company and Provider/Subcontractor shall collect information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees, and (ii) Company and Provider/Subcontractor shall report to HFS quarterly, in a format and in the detail specified by HFS, information on the total number of units of each dosage form and strength and package size by National Drug Code of each such covered outpatient drug dispensed to Enrollees. [FHP-ACA Contract §§ 5.2.5.4.1, 5.2.5.4.2]

(vi) Company and Provider/Subcontractor shall establish and maintain a generic drug Maximum Allowable Cost (MAC) dispute-resolution process, subject to approval by HFS. The MAC dispute-resolution process shall enable pharmacies to report pricing disputes to the Company and/or

Provider/Subcontractor up to sixty (60) days from the claim date and Company and/or Provider/Subcontractor is required to resolve the pricing dispute within twenty-one (21) days by adjusting the reimbursement rate to represent the average acquisition cost of the drug, or by informing the pharmacy of alternative generic equivalent products that can be purchased at or below the Company's existing MAC price. [ICP Contract § 5.1.7.5; FHP-ACA Contract § 5.2.5.5]

(vii) Company and Provider/Subcontractor shall develop and implement a system, including policies and procedures, coverage criteria, and processes for their Drug Utilization Review (DUR) program. The DUR program shall include a prospective review process for all drugs prior to dispensing and all non-formulary drug requests, and a retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. Company and Provider/Subcontractor are required to report prospective and retrospective DUR activities to HFS quarterly, and to assist in data collection and reporting to HFS of data necessary to complete the federal CMS DUR annual report. [ICP Contract § 5.1.7.6; FHP-ACA Contract § 5.2.5.6]

(viii) Company and Provider/Subcontractor shall comply with the pharmacy prior-authorization provisions and requirements set forth in Section 5.16.6 of each of the State Contracts, which requires that Company and/or Provider/Subcontractor must authorize or deny a prior-authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization. [ICP Contract § 5.16.6; FHP-ACA Contract § 5.16.6]

(ix) Company and Provider/Subcontractor shall not permit or allow, whether by contract, written policy, or procedure, any individual or entity to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act (codified at 410 ILCS 620/3.14). [215 ILCS 134/30(b)]

12. Children's Mental Health Service Requirements. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to any behavioral-health Covered Services that Provider/Subcontractor provides to Enrollees under the age of twenty one (21):

a. Provider/Subcontractor shall administer all such behavioral-health benefits in accordance with the provisions and requirements of Attachment XXII of the FHP-ACA Contract and in accordance with all applicable State and federal laws and regulations. [FHP-ACA Contract, Attachment XXII]

b. If Provider is an inpatient psychiatric Provider, it shall administer a physical examination to the Enrollee within twenty-four (24) hours after admission when that Enrollee requires admission to an appropriate inpatient institutional treatment setting. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.iv.]

c. Provider shall comply with Company's procedures with respect to discharge and transitional planning related to an appropriate inpatient institutional treatment setting, and shall cooperate with Company in the education and training of the Enrollee's family on how to use the "crisis safety plans" while the Enrollee is receiving inpatient institutional treatment. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.v.5.]

d. If Provider/Subcontractor provides Mobile Crisis Response Services in connection with the State Contracts:

(i) Provider/Subcontractor shall ensure that the staff providing those services hold the following credentials: (a) Mental Health Professional (MHP) with direct access to a Qualified Mental Health professional; (b) Qualified Mental Health Professional; or (c) Licensed Practitioner of the Healing Arts. [FHP-ACA Contract, Attachment XXII, ¶ 3.f.]

(ii) Provider/Subcontractor shall provide immediate crisis and stabilization services when an Enrollee in crisis can be stabilized in the community. [FHP-ACA Contract, Attachment XXII, ¶ 4.a.i.]

(iii) Provider/Subcontractor shall establish a "crisis safety plan" for all Enrollees presenting in behavioral-health crisis that is unique to the Enrollee and the circumstances leading to the crisis situation. [FHP-ACA Contract, Attachment XXII, ¶¶ 4.a.ii., 4.b.i.]

(iv) Provider/Subcontractor shall provide the Enrollee's family with contact information that may be used at any time, 24 hours a day, to contact Company in moments of crisis. [FHP-ACA Contract, Attachment XXII, ¶ 4.a.iv.]

(v) Provider/Subcontractor shall provide families of Enrollees with physical copies of the "crisis safety plan" (a) prior to the completion of the crisis screening event for any Enrollee stabilized in the community, and (b) prior to discharge of the Enrollee from an inpatient psychiatric hospital for any Enrollee that is admitted to such a facility. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.ii.]

(vi) Provider/Subcontractor shall educate and orient the Enrollee's family to the components of the "crisis safety plan" to ensure that the plan is reviewed with the family regularly, and to detail how the plan is updated as necessary. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.iii.]

(vii) Provider/Subcontractor shall share the "crisis safety plan" with all necessary medical professionals, including care coordinators, consistent with the authorizations established by consent or release. [FHP-ACA Contract, Attachment XXII, ¶ 4.b.iv.]

(viii) Provider/Subcontractor shall facilitate the Enrollee's admission to an appropriate inpatient institutional treatment setting when the Enrollee in crisis cannot be stabilized in the community. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.i.]

(ix) Provider/Subcontractor shall inform the Enrollee's parents, guardian, caregivers, or residential staff about all of the available service providers and pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting. [FHP-ACA Contract, Attachment XXII, ¶ 4.c.ii.]

13. Third-Party Payment Sources; Coordination of Benefits. Provider/Subcontractor acknowledges and agrees that Medicaid payment, under the State Contracts or otherwise, is secondary to other sources of payment (including Medicare) for Covered Services provided to Enrollees, and that Medicaid (and consequently Company, as a Medicaid MCO of the State) is the payer of last resort. Provider/Subcontractor furthermore acknowledges and agrees that to the extent Medicare has primary responsibility for a Covered Service, Company's obligation to pay for that Covered Service is only triggered if the State would have had a payment obligation as secondary payor on that Covered Service. [MLTSS Contract § 5.1] Provider/Subcontractor also acknowledges and agrees that when Company is aware of third-party sources of payment for Covered Services, Company is required to "cost avoid" (*i.e.*, deny) the associated claim and to redirect Provider/Subcontractor to bill that third-party source of payment as the primary payor.

14. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to submit financial and expense-related reports/data to the State relating to the risk adjustment and Medical Loss Ratio (MLR) adjustment set forth in the State Contracts. [ICP Contract §§ 7.4, 7.11; FHP-ACA Contract §§ 7.4, 7.11; MLTSS Contract §§ 7.4, 7.11]

b. Company's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [ICP Contract §§ 9.1.37, 9.1.38; FHP-ACA Contract §§ 9.1.36, 9.1.37; MLTSS Contract §§ 9.1.36, 9.1.37]

c. Company's obligation to provide a "medical home," as that term is used in the State Contracts, for its Enrollees. [ICP Contract §§ 5.5.7, 5.9.2; FHP-ACA Contract §§ 5.6.7, 5.9.2; MLTSS Contract §§ 5.5.7, 5.8.2]

d. Company's obligation to develop the Enrollee's care plan and to encourage Provider/Subcontractor to support Enrollees in directing their own care and in development of the Enrollee's care plan. [ICP Contract § 5.12.6; FHP-ACA Contract §§ 5.14.5, 5.14.8.1.3; MLTSS Contract §§ 5.13.5, 5.13.9.1, 5.13.9.2.3]

e. Company's obligation to avoid unnecessary utilization of emergency services by Enrollees and to promote care management through the Enrollees' primary care providers (PCPs) or "medical home." [ICP Contract § 5.17.1.5; FHP-ACA Contract § 5.17.1.5]

f. Company's obligation to establish and maintain an HFS-approved peer-review program to review the quality of care that Provider/Subcontractor provides to Enrollees. [ICP Contract § 5.19.5; FHP-ACA Contract § 5.19.5; MLTSS Contract § 5.18.5]

g. Company's obligation to provide orientation, education, and training for Provider/Subcontractor as set forth in the State Contracts, including without limitation (i) training on how to identify, recognize potential concerns related to, and report on suspected or alleged abuse, neglect, and exploitation being suffered by Enrollees, and (ii) education on the application of required clinical guidelines. [ICP Contract §§ 5.9, 5.20.1, 5.20.2, Attachment XI ¶ 9, Attachment XXI ¶ 3; FHP-ACA Contract §§ 5.9, 5.20.4, 5.20.5, Attachment XI ¶ 9, Attachment XXI ¶ 3; MLTSS Contract §§ 5.8, 5.19.4, 5.19.5, Attachment XI ¶ 9, Attachment XXI ¶ 3]

h. Company's obligation to participate in any State-required performance-improvement projects. [ICP Contract § 7.16.5; FHP-ACA Contract § 7.16.5; MLTSS Contract § 7.16.5]

i. Company's obligation to remit to Provider/Subcontractor, if applicable, any "hospital access payments" authorized under 305 ILCS 5/5A-12.2(s)–(t) and 305 ILCS 5/5A-12.5 (Public Act 98-651, enacted June 14, 2014). [ICP Contract § 7.1.5; FHP-ACA Contract § 7.1.2]

j. Company's obligation to respond to any letter of concern, written deficiency notice, or request for a corrective action plan that Company receives from the State relating to Provider/Subcontractor or the services that are within the scope of the Agreement. [ICP Contract § 7.16.6; FHP-ACA Contract § 7.16.6; MLTSS Contract § 7.16.6]

k. Company's obligations and responsibilities relating to the "HMO self-evaluation structure" and associated activities set forth in 77 Ill. Admin. Code § 240.60. [77 Ill. Admin. Code § 240.50(d)(1)(C)]

l. Company's obligations to coordinate Enrollees' care with any other entities involved in managing or coordinating that care, to collaborate and deliberate with those other entities as needed for care coordination and health-care decisions, to share with and receive information from those other entities as needed for care coordination, and to obtain any permissions (including without limitation any signed written permissions) necessary to facilitate such information-sharing, care coordination, and collaboration. [MLTSS Contract §§ 5.9.4, 5.10.1.6, 5.12.2.8, 5.13.9.1]

15. Notice of Legal Action. If Provider/Subcontractor, its parent, or one of its affiliates becomes a party to any litigation, investigation, or transaction that may reasonably be considered to have a material impact on

Provider/Subcontractor's ability to perform under the Agreement, Provider/Subcontractor shall immediately notify Company in writing. [ICP Contract § 9.1.24; FHP-ACA Contract § 9.1.24; MLTSS Contract § 9.1.24]

16. State Review of Agreement. Provider/Subcontractor acknowledges and agrees that Company may be required to submit a copy of the Agreement to HFS for review, and that HFS reserves the right to require Company to amend the Agreement as reasonably necessary to conform to Company's duties and obligations under the State Contracts. [ICP Contract § 5.28.10; FHP-ACA Contract § 5.28.10; MLTSS Contract § 5.27.10]

17. Termination of Agreement and Effect Thereof.

a. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the parties. Furthermore, in the event this Illinois Medicaid Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or Product Participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties.

b. Notwithstanding anything in the Agreement to the contrary, if either Company or Provider/Subcontractor seeks (i) to terminate the Agreement "with cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least sixty (60) days' written notice to the other party; or (ii) to terminate the Agreement "without cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least ninety (90) days' written notice to the other party. Furthermore, Provider/Subcontractor shall cooperate with Company with respect to Company's obligation to provide timely notice to Enrollees of any termination that would curtail or eliminate services to such Enrollees, with such notice to be sent (i) at least sixty (60) days prior to that termination, or (ii) immediately, if Company receives less than sixty (60) days' notice of that termination from Provider/Subcontractor. The notice to be sent to Enrollees shall include instructions regarding referrals that have previously been issued and appointments that may be pending. [50 Ill. Admin. Code § 5241.50(a)(5)–(6); 305 ILCS 5/5F-40(a)]

c. Notwithstanding anything in the Agreement to the contrary, Company shall retain the right to terminate the Agreement, or impose other sanctions, if the performance of Provider/Subcontractor is inadequate. Company shall monitor the performance of Provider/Subcontractor on an ongoing basis, shall subject Provider/Subcontractor to formal review on no less than a triennial basis, and to the extent deficiencies or areas for improvement are identified during an informal or formal review, shall require Provider/Subcontractor to take appropriate corrective action. Furthermore, Company shall promptly terminate the Agreement if Provider/Subcontractor is or becomes terminated, barred, or suspended, or has voluntarily withdrawn as a result of a settlement agreement, under either Section 1128 or Section 1128A of the Social Security Act, from participating in any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act or are otherwise excluded from participation in the HFS Medical Program. [ICP Contract §§ 5.28.7, 5.28.9; FHP-ACA Contract §§ 5.28.7, 5.28.9; MLTSS Contract §§ 5.27.7, 5.27.9]

18. Maintenance, Access to, and Confidentiality of Records.

a. Provider/Subcontractor shall maintain books and records relating to the performance of the State Contracts and the Agreement and necessary to support amounts charged under the State Contracts and the Agreement. Books and records, including information stored in databases or other computer systems, shall be maintained by Provider/Subcontractor for a period of three (3) years from the later of the date of final payment under the Agreement or completion of the Agreement, or such longer time as may be required by federal law or regulation. Books and records required to be maintained under this provision shall be accessible for review or audit by representatives of Company or any Authorized Persons (along with the Executive

Inspector General and the Chief Procurement Officer) upon reasonable notice and during normal business hours. Such access shall include the right to make and/or obtain a copy (in either electronic or hardcopy form) of such books and records. Provider/Subcontractor shall cooperate fully with any such audit and with any investigation conducted by any of these entities. Failure to maintain the books and records required by this provision shall establish a presumption in favor of the State for the recovery of any funds paid by the State under the State Contracts for which adequate books and records are not available to support the purported disbursement. Provider/Subcontractor shall not impose a charge for audit or examination of Provider/Subcontractor's books and records. [ICP Contract § 9.1.2; FHP-ACA Contract § 9.1.2; MLTSS Contract § 9.1.2]

b. Provider/Subcontractor may have or gain access to confidential data or information owned or maintained by the State or Company in the course of carrying out Provider/Subcontractor's responsibilities under the Agreement and/or the State Contracts. Provider/Subcontractor shall presume all information received from the State or Company, or to which it gains access pursuant to the Agreement and/or the State Contracts, is confidential. No confidential data collected, maintained, or used in the course of performance of the Agreement and/or the State Contracts shall be disseminated except as authorized by law and with the written consent of the State and/or Company, as applicable, either during the term of the State Contracts or thereafter, unless otherwise expressly provided in the State Contracts. Provider/Subcontractor must return any and all data collected, maintained, created, or used in the course of the performance of the Agreement and/or the State Contracts, in whatever form it is maintained, promptly at the earlier of the termination of the Agreement or the termination of the State Contracts, or earlier at the request of the State, or notify the State and/or Company, as applicable, in writing of its destruction. The foregoing obligations shall not apply to confidential data or information that is: (i) lawfully in Provider/Subcontractor's possession prior to its acquisition from the State and/or Company; (ii) received in good faith from a third-party not subject to any confidentiality obligation to the State and/or Company; (iii) now is or later becomes publicly known through no breach of confidentiality obligation by Provider/Subcontractor; or (iv) is independently developed by Provider/Subcontractor without the use or benefit of the confidential information of the State and/or Company. [ICP Contract § 9.1.6; FHP-ACA Contract § 9.1.6; MLTSS Contract § 9.1.6]

c. Provider/Subcontractor shall ensure that all information, records, data, and data elements pertaining to applicants for and recipients of public assistance, or to providers, facilities, and associations, shall be protected from unauthorized disclosure by Provider/Subcontractor and Provider/Subcontractor's employees, by Provider/Subcontractor's corporate affiliates and their employees, and by Provider/Subcontractor's subcontractors and their employees, pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 U.S.C. § 654(26); 42 C.F.R. Part 431, Subpart F; and 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subparts A and E. To the extent that Provider/Subcontractor, in the course of performing under the terms of the Agreement, serves as a business associate of Company and/or HFS, as "business associate" is defined in the HIPAA Privacy Rule (45 C.F.R. § 160.103), Provider/Subcontractor shall assist Company and/or HFS in responding to the client as provided in the HIPAA Privacy Rule, and shall maintain for a period of six (6) years any records relevant to an individual's eligibility for services under the HFS Medical Program. [ICP Contract § 9.1.21; FHP-ACA Contract § 9.1.21; MLTSS Contract § 9.1.21]

d. Provider/Subcontractor, to which Company provides Enrollee PHI that Company has received from HFS or created or received by Company on behalf of HFS, agrees to the same restrictions, conditions, and requirements that apply under the terms of the State Contracts to Company with respect to such information. [ICP Contract, Attachment VI § C.5; FHP-ACA Contract, Attachment VI § C.5; MLTSS Contract, Attachment VI §§ B.4, B.5]

19. Medical Records. With respect to Enrollee medical records:

a. In addition to the requirements set forth in the Agreement, Provider/Subcontractor shall maintain Enrollee medical records in a timely, legible, accurate, current, complete, and organized manner, with appropriate dates and identification and initialing/signature of the Provider/Subcontractor, to facilitate retrieval and compilation of records, to ensure Enrollee continuity of care, and to permit effective and confidential

patient care and quality review. For each encounter or episode of care that Provider/Subcontractor has with an Enrollee, Provider/Subcontractor shall place the following information into the Enrollee's medical records: (1) the reason for the encounter; (2) evidence of the Provider/Subcontractor's assessment of the Enrollee's health problems; (3) current diagnosis of the Enrollee, including the results of any diagnostic tests; (4) the plan of treatment, including any therapies and health education; (5) any medical history relevant to the current episode of care; and (6) confirmation that all outcomes of ancillary reports, such as laboratory tests and x-rays, have been reviewed by the individual or entity who ordered the reports and that follow-up actions have been taken regarding report results that are deemed significant by the individual or entity who ordered those reports. [77 Ill. Admin. Code §§ 240.50(c)(1), 240.90(a)–(b); ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3; MLTSS Contract § 5.22.3]

b. Provider/Subcontractor shall ensure that Enrollee medical records contain documented efforts to obtain Enrollee consent when required by law. Provider/Subcontractor shall furthermore only release Enrollee medical records to Authorized Persons, or to any primary care provider (PCP), women's health care provider (WHCP), or other Provider of Enrollee (subject to Enrollee's consent when required by law), and shall only release original Enrollee medical records in accordance with federal or State law, court orders, subpoenas, or a valid records-release form executed by the Enrollee. Provider/Subcontractor shall protect the confidentiality and privacy of minors, and shall abide by all federal and State laws regarding the confidentiality and disclosure of medical records, mental health records, and any other information about Enrollees. Provider/Subcontractor shall produce Enrollee medical records to HFS upon request. [ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3; MLTSS Contract § 5.22.3]

c. If Provider/Subcontractor is an Enrollee's primary care provider (PCP), Provider/Subcontractor shall furthermore maintain a permanent medical record for that Enrollee to ensure continuity of care. The medical record for each Enrollee who has had a routine, scheduled appointment with his/her primary care provider (PCP) shall include the following information: (1) identification; (2) patient history; (3) known past surgical procedures; (4) known past and current diagnoses and problems; and (5) known allergies and untoward reactions to drugs. [77 Ill. Admin. Code § 240.90(c); ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

d. If Enrollee changes PCPs or "medical homes," Provider/Subcontractor shall forward Enrollee's medical records or copies thereof to the new PCP or "medical home" promptly upon Enrollee's transfer. [ICP Contract § 5.23.3; FHP-ACA Contract § 5.23.3]

e. Provider/Subcontractor shall only record diagnosis codes in Enrollee's medical records at the time of creation of that medical record, and shall not retroactively adjust any such diagnosis codes except to correct errors. [ICP Contract § 7.4.1; FHP-ACA Contract § 7.4.1]

20. Use of Hospitalists. Neither Company nor Provider/Subcontractor shall require or otherwise mandate, whether by contract, written policy, or procedure, any Enrollee to substitute his or her participating primary care provider (PCP) during inpatient hospitalization, such as with a hospitalist physician, without the agreement of that Enrollee's participating primary care provider (PCP). Company and Provider/Subcontractor (if applicable) shall inform Enrollees of any policies, recommendations, or guidelines concerning the substitution of the Enrollee's primary care provider (PCP) when hospitalization is necessary in the manner set forth in 215 ILCS 5/15(d)–(e). [215 ILCS 134/30(c)]

21. Provider Enrollment, Credentialing, Licensure, and Privileges.

a. Provider/Subcontractor shall be enrolled as a provider in the HFS Medical Program (as defined below), if such enrollment is required by HFS's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. Provider/Subcontractor shall not, in turn, contract or subcontract with an individual or entity that has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement. For purposes of this provision, the term "HFS Medical

Program" means the (i) Illinois Medical Assistance Program administered under Article V of the Illinois Public Aid Code (305 ILCS 5/5-1 *et seq.*) or its successor program, and Titles XIX (42 U.S.C. § 1396 *et seq.*) and XXI (42 U.S.C. § 1397aa *et seq.*) of the Social Security Act, and Section 12-4.35 of the Illinois Public Aid Code (305 ILCS 5/12-4.35); and (ii) the State Children's Health Insurance Program administered under 215 ILCS 106 and Title XXI of the Social Security Act (42 U.S.C. § 1397aa *et seq.*). [ICP Contract §§ 1.71, 5.28.4; FHP-ACA Contract §§ 1.75, 5.28.4; MLTSS Contract §§ 1.74, 5.27.4]

b. Provider shall comply with all credentialing and recredentialing policies and procedures that Company implements to verify Provider's credentials, including without limitation by completing a credentialing application in accordance with applicable policies and procedures. Furthermore, Provider shall comply with all applicable credentialing/recredentialing standards and requirements set forth in the State Contracts and in applicable federal and State laws, regulations, and written policies. [ICP Contract § 5.7.1, Attachment XI ¶ 8; FHP-ACA Contract § 5.8.1, Attachment XI ¶ 8; MLTSS Contract § 5.7.1, Attachment XI ¶ 8]

c. If Provider/Subcontractor operates a laboratory testing site that provides services to Enrollees, (i) that site shall possess a valid Clinical Laboratory Improvement Amendment (CLIA) certificate and comply with the CLIA regulations found at 42 C.F.R. Part 493, and (ii) Provider/Subcontractor shall report lab values to Company directly. [ICP Contract §§ 5.19.2, 5.28.9.4; FHP-ACA Contract §§ 5.19.2, 5.28.9.4]

d. If Provider is a physician, such physician Provider shall have and maintain admitting privileges and, as appropriate, delivery privileges at a hospital that is also a participating Provider with Company; or, in lieu of these admitting and/or delivery privileges, such physician Provider shall have a written referral agreement with a separate physician who is a participating Provider with Company and who has such privileges at a hospital that is also a participating Provider with Company. Such physician Provider shall coordinate care with the referring physician and shall ensure that Enrollee medical records are appropriately transferred; the physicians' written referral agreement shall contain appropriate provisions that document and require such coordination of care and transfer of medical records. [ICP Contract § 5.28.1.2; FHP-ACA Contract § 5.28.1.2; MLTSS Contract § 5.27.1.2]

e. If Provider/Subcontractor provides long-term care and HCBS services under the Agreement, Provider/Subcontractor shall be approved and authorized by the State to provide such Covered Services, and shall only provide to Enrollees those particular Covered Services for which they are approved and authorized. [FHP-ACA Contract § 5.8.5; MLTSS Contract § 5.7.5]

22. Disclosure of Ownership and Control; Prohibited Relationships; Background Checks.

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in federal health care programs, or is 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, Provider/Subcontractor shall disclose to Company: any required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest information; and information on any criminal convictions regarding Provider/Subcontractor and any owner(s) and managing employee(s) at the time the Agreement is executed and annually thereafter, and any time there are changes to such information. [ICP Contract § 9.2.34; FHP-ACA Contract § 9.2.34; MLTSS Contract § 9.2.34]

b. No Provider/Subcontractor, no individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider/Subcontractor, and no officer, director, agent, or managing employee (*i.e.*, general manager, business manager, administrator, director, or like individual who exercises

operational or managerial control over that Provider/Subcontractor or who directly or indirectly conducts the day-to-day operation of that Provider/Subcontractor) shall be an entity or individual: (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)–(3) of the Social Security Act (42 U.S.C. § 1320a-7(b)(1)–(3)); (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a State health care program. [ICP Contract § 9.2.34; FHP-ACA Contract § 9.2.34; MLTSS Contract § 9.2.34]

c. Provider/Subcontractor shall not be an Excluded Person (as that term is defined below), and shall not employ, subcontract with, or affiliate with an Excluded Person. The term "Excluded Person" means any individual or entity that (i) under Section 1128 of the Social Security Act, is or has been terminated, barred, suspended, or otherwise excluded from participation in, or as the result of a settlement agreement has voluntarily withdrawn from participation in, any program under federal law, including any program under Titles IV, XVIII, XIX, XX or XXI of the Social Security Act; (ii) has not been reinstated in the program after a period of exclusion, suspension, debarment, or ineligibility; or (iii) has been convicted of a criminal offense related to the provision of items or services to a federal, state, or local government entity within the last ten (10) years. Provider/Subcontractor acknowledges and agrees that under the State Contracts, Company must terminate its relationship with Provider/Subcontractor immediately upon learning that such Provider/Subcontractor meets the definition of an Excluded Person, and must notify the HFS OIG of the termination. [ICP Contract §§ 5.22, 9.1.32; FHP-ACA Contract §§ 5.22, 9.1.32; MLTSS Contract §§ 5.21, 9.1.32]

d. Provider/Subcontractor acknowledges and agrees that prior to entering into the Agreement, Company may be required to submit a disclosure statement to HFS identifying any agreements, Providers, and/or Subcontractors in which any of the following have a financial interest of five percent (5%) or more: (a) any individual or entity also having a financial interest of five percent (5%) or more in Company or Company's affiliates as defined by 42 C.F.R. § 455.101; (b) any director, officer, trustee, partner, or employee of Company or Company's Affiliates; and (c) any member of the immediate family of any individual or entity designated above. [ICP Contract § 5.28.12; FHP-ACA Contract § 5.28.12; MLTSS Contract § 5.27.12]

e. Provider/Subcontractor acknowledges and agrees that the State may conduct, at the State's expense and whenever the State deems it reasonably necessary for security reasons, criminal and driver history background checks of Provider/Subcontractor and its officers, employees, or agents, and furthermore acknowledges and agrees that Provider/Subcontractor shall immediately reassign any such individual who, in the opinion of the State, does not pass the background checks. [ICP Contract § 9.1.13; FHP-ACA Contract § 9.1.13; MLTSS Contract § 9.1.13]

23. Fraud, Abuse and Misconduct. Provider/Subcontractor shall report immediately in writing to Company and to the HFS OIG any suspected fraud, abuse, or misconduct associated with any service or function provided for under the Agreement and/or the State Contracts by any parties directly or indirectly affiliated with the Agreement and/or the State Contracts, including without limitation Company and Company's staff, Provider/Subcontractor and its employees and subcontractors, and HFS employees or contractors. Provider/Subcontractor shall make this report to Company and to the HFS OIG within three (3) days after first suspecting fraud, abuse, or misconduct. Provider/Subcontractor shall not conduct any investigation of the suspected fraud, abuse, or misconduct without the express concurrence of the HFS OIG; the foregoing notwithstanding, Provider/Subcontractor may conduct and continue investigations necessary to determine whether reporting is required under this provision. Provider/Subcontractor must report the results of such an investigation to the HFS OIG as described above. Provider/Subcontractor shall cooperate with all investigations of suspected fraud, abuse, or misconduct reported pursuant to this provision. Nothing in this provision precludes Company or Provider/Subcontractor from establishing measures to maintain quality of services and control costs that are consistent with their usual business practices, from conducting themselves in accordance with their respective legal or contractual obligations, or from taking internal personnel-related actions. [ICP Contract §§ 5.31.1, 9.1.29; FHP-ACA Contract §§ 5.31.1, 9.1.29; MLTSS Contract §§ 5.30.1, 9.1.29]

24. Business Enterprise Program (BEP) Registration. In the event that Provider/Subcontractor is a minority-owned business, a female-owned business, or a business owned by persons with disabilities, then Provider/Subcontractor shall seek and obtain State certification as a Business Enterprise Program (BEP) vendor under the Business Enterprise Program Act for Minorities, Females and Persons with Disabilities. Provider/Subcontractor shall furthermore cooperate with Company with respect to Company's obligations under the State Contract related to the Business Enterprise Program (BEP) and shall, among other things, maintain a record of all relevant data with respect to the utilization of BEP-certified individuals and entities, including, but not limited to, payroll records, invoices, canceled checks, and books of account, for a period of at least five (5) years after the completion of the Agreement. [ICP Contract §§ 2.9.2, 7.16.2; FHP-ACA Contract §§ 2.9.2, 7.16.2; MLTSS Contract §§ 2.9.2, 7.16.2]

25. Marketing Activities. Provider/Subcontractor shall not engage in any inappropriate or unallowable marketing activities and practices as set forth in the State Contracts and 42 C.F.R. § 438.104, and shall submit to Company for its review any marketing or information materials of Provider/Subcontractor that relate to the State Contracts, prior to disseminating same. Provider/Subcontractor furthermore shall not induce any employees of the State to improperly reveal any confidential information regarding Enrollees or otherwise use such confidential information in a fraudulent manner. [ICP Contract § 4.16.3; FHP-ACA Contract § 4.16.3; MLTSS Contract § 4.16.3]

26. Compliance with Laws, the State Contracts, and Company Policies and Procedures.

a. Provider/Subcontractor shall perform all services and other duties under the Agreement in accordance and compliance with, and subject to, all applicable federal, State, and local laws, rules, ordinances, regulations, orders, federal circulars, and license and permit requirements in the performance of the Agreement, including without limitation, the Managed Care Reform and Patient Rights Act (215 ILCS 134/ 1 *et seq.*), the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by the Illinois Department of Financial and Professional Regulation, the Illinois Department of Public Health, and/or federal CMS. Company shall be in compliance with applicable tax requirements and shall be current in payment of such taxes. Company shall obtain at its own expense all licenses and permissions necessary for the performance of the Agreement. [ICP Contract §§ 2.2, 2.5, 9.1.12; FHP-ACA Contract §§ 2.2, 2.5, 9.1.12; MLTSS Contract §§ 2.2, 2.5, 9.1.12]

b. Provider/Subcontractor shall be bound by the terms and conditions of the State Contracts that are appropriate to the services provided by, or activities delegated to, Provider/Subcontractor in connection with the State Contracts. These terms and conditions include, without limitation, the record-keeping and audit provisions of the State Contracts, such that the Authorized Persons shall have the same rights to audit and inspect Provider/Subcontractor (and any downstream providers or subcontractors thereof) as they have to audit and inspect Company. [ICP Contract § 5.28.1.1; FHP-ACA Contract § 5.28.1.1; MLTSS Contract § 5.27.1.1]

c. Provider/Subcontractor shall comply with the prior-authorization requirements and processes set forth in Company's policies and procedures. [ICP Contract §§ 5.16.5, 5.16.6; FHP-ACA Contract § 5.16.5, 5.16.6; MLTSS Contract §§ 5.15.5, 5.15.6]

d. Provider/Subcontractor shall comply with all utilization-management and peer-review programs, processes, and timeframes established by Company. [ICP Contract, Attachment XII ¶ 4; FHP-ACA Contract, Attachment XII ¶ 4; MLTSS Contract, Attachment XII ¶ 4]

27. State Employee Handbook. If Provider/Subcontractor or any of its employees and subcontractors provide services under the Agreement at a location controlled by HFS or any other State agency, Provider/Subcontractor shall abide by all applicable provisions of the controlling State agency's Employee Handbook. [ICP Contract § 9.1.27; FHP-ACA Contract § 9.1.27; MLTSS Contract § 9.1.27]

28. Prohibition on Gifts. Provider/Subcontractor and its principals, employees, and subcontractors are prohibited from giving gifts to HFS employees, and from giving gifts to, or accepting gifts from, any individual or entity that has a contemporaneous contract with HFS involving duties or obligations related to the Agreement and/or the State Contracts. [ICP Contract § 9.1.30; FHP-ACA Contract § 9.1.30; MLTSS Contract § 9.1.30]

29. No Transfer of Liability to Providers. Neither Company nor Subcontractor shall transfer or attempt to transfer to any health care provider, by indemnification, hold harmless, or contribution requirements that are set forth in any contract, written policy, or procedure, any liability relating to activities, actions, or omissions of Company and/or Subcontractor or their respective officers, employees, or agents; provided, however that nothing in this provision shall relieve any health care provider from liability for his, her, or its own negligence in the performance of his, her, or its duties arising from treatment of an Enrollee. [215 ILCS 134/95]

30. Capitated Contracts. If Company compensates Provider/Subcontractor under the Agreement on a capitated basis for furnishing, arranging, or providing health care services:

a. Provider/Subcontractor agrees that in no event, including but not limited to nonpayment by Company of amounts due to Provider/Subcontractor under the Agreement, insolvency of Company, or any breach of the Agreement by Company, shall Provider/Subcontractor or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Enrollee or persons acting on the Enrollee's behalf (other than Company) for services provided pursuant to the Agreement, except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Enrollees and persons acting on the Enrollees' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider/Subcontractor and the Enrollee or persons acting on the Enrollee's behalf (other than Company). [50 Ill. Admin. Code § 5241.50(e)]

b. Provider/Subcontractor shall submit timely encounter data/records for all Covered Services that it has provided to Enrollees, in the format specified by the State, so that Company can meet the encounter-reporting specifications and requirements set forth in the State Contracts. Provider/Subcontractor shall be responsible for transmitting all data to Company as required by 42 C.F.R. § 438. [ICP Contract § 7.11.3; FHP-ACA Contract §§ 5.6.6, 7.11.3; MLTSS Contract §§ 5.5.6, 7.11.3]

c. If Provider/Subcontractor is a "Managed Care Organization" as that term is defined in 50 Ill. Admin. Code § 5241.20, Provider/Subcontractor shall submit to Company copies of Provider/Subcontractor's quarterly financial statements, which shall include Provider/Subcontractor's balance sheet and statements of income and cash flow within forty-five (45) days after the end of each fiscal period. In addition, Provider/Subcontractor shall submit, within ninety (90) days after the end of Provider/Subcontractor's fiscal year, copies of Provider/Subcontractor's audited annual financial statements prepared in accordance with generally accepted accounting principles, if available. Provider/Subcontractor acknowledges and agrees that HFS, at its discretion, may require Company to submit for HFS's inspection the financial statements that Company has received from Provider/Subcontractor (which such financial statements shall be deemed confidential by HFS). Provider/Subcontractor agrees to fully cooperate with, and disclose all relevant information requested by, Company's actuaries for the preparation of such actuaries' opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16. Company acknowledges that in the event of Provider/Subcontractor's insolvency, Company is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Company's Enrollees. [50 Ill. Admin Code §5241.50(d)] For purposes of this provision, "Managed Care Organization" or "MCO" means a partnership, association, corporation, or other legal entity, including but not limited to individual practice associations

(IPAs) and physician hospital organizations (PHOs), that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services. [50 Ill. Admin. Code § 5241.20]

31. Required Certifications of Provider/Subcontractor. Provider/Subcontractor acknowledges and agrees that its compliance with Section 9.2 of each of the State Contracts and each subsection of Section 9.2 (collectively, the "Standard Certifications") is a material requirement and condition of this Agreement during the entire term thereof, including during any renewal periods. By executing the Agreement, Provider/Subcontractor certifies compliance with the Standard Certifications in their entirety, and Provider/Subcontractor is under a continuing obligation to remain in compliance with, and to report any non-compliance with respect to, the Standard Certifications. Furthermore, Provider/Subcontractor shall include the Standard Certifications in any subcontracts or other contracts with its downstream entities or related entities that Provider/Subcontractor enters into in connection with the State Contracts. During the term of the State Contracts, Provider/Subcontractor shall confirm compliance with the Standard Certifications in the manner and format determined by the State by the date specified by the State, and in no event later than July 1 of each year that the State Contracts remains in effect. As part of each Standard Certification, Provider/Subcontractor acknowledges and agrees that if Provider/Subcontractor or its subcontractors, downstream entities, or related entities provide false information, or fail to be or remain in compliance with the Standard Certifications, one or more of the following sanctions will apply: (a) the Agreement may be void by operation of law; (b) the State may void the Agreement; and (c) Provider/Subcontractor and its subcontractors, downstream entities, or related entities may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty. [ICP Contract § 9.2.1; FHP-ACA Contract § 9.2.1; MLTSS Contract § 9.2.1]

The Standard Certifications are set forth below:

a. Provider/Subcontractor certifies it and its employees will comply with applicable provisions of the United States Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101, *et seq.*), and applicable rules in the performance of this Agreement. [ICP Contract § 9.2.2; FHP-ACA Contract § 9.2.2; MLTSS Contract § 9.2.2]

b. Provider/Subcontractor certifies, if applicable, that it is not in default on an educational loan (5 ILCS 385/3). This applies to individuals, sole proprietorships, partnerships, and individuals as members of LLCs. [ICP Contract § 9.2.3; FHP-ACA Contract § 9.2.3; MLTSS Contract § 9.2.3]

c. Provider/Subcontractor (if an individual, sole proprietor, partner, or an individual as member of an LLC) certifies, if applicable, that it has not received (i) an early retirement incentive prior to 1993 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133.3, or (ii) an early retirement incentive on or after 2002 under Section 14-108.3 or 16-133.3 of the Illinois Pension Code, 40 ILCS 5/14-108.3 and 40 ILCS 5/16-133 (30 ILCS 105/15a). [ICP Contract § 9.2.4; FHP-ACA Contract § 9.2.4; MLTSS Contract § 9.2.4]

d. Provider/Subcontractor certifies, if applicable, that it is a properly formed and existing legal entity (30 ILCS 500/1.15.80, 20-43), and as applicable has obtained an assumed name certificate from the appropriate authority, or has registered to conduct business in Illinois and is in good standing with the Illinois Secretary of State. [ICP Contract § 9.2.5; FHP-ACA Contract § 9.2.5; MLTSS Contract § 9.2.5]

e. Provider/Subcontractor certifies that it has neither been convicted of bribing or attempting to bribe an officer or employee of the State or any other state, nor made an admission of guilt of such conduct that is a matter of record (30 ILCS 500/50-5). [ICP Contract § 9.2.7; FHP-ACA Contract § 9.2.7; MLTSS Contract § 9.2.7]

f. If Provider/Subcontractor has been convicted of a felony, Provider/Subcontractor certifies at least five (5) years have passed after the date of completion of the sentence for such felony, unless no person held responsible by a prosecutor's office for the facts upon which the conviction was based continues to have any involvement with the business (30 ILCS 500/50-10). [ICP Contract § 9.2.8; FHP-ACA Contract § 9.2.8; MLTSS Contract § 9.2.8]

g. If Provider/Subcontractor, or any officer, director, partner, or other managerial agent of Provider/Subcontractor, has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law of 1953, Provider/Subcontractor certifies that at least five (5) years have passed since the date of the conviction. Provider/Subcontractor further certifies that it is not barred from being awarded a contract and acknowledges that the State shall declare the Agreement void if this certification is false (30 ILCS 500/50-10.5). [ICP Contract § 9.2.9; FHP-ACA Contract § 9.2.9; MLTSS Contract § 9.2.9]

h. Provider/Subcontractor certifies that it is not barred from having a contract with the State based on violating the prohibition on providing assistance to the State in identifying a need for a contract (except as part of a public request for information process) or by reviewing, drafting, or preparing a solicitation or similar documents for the State (30 ILCS 500/50-10.5e). [ICP Contract § 9.2.10; FHP-ACA Contract § 9.2.10; MLTSS Contract § 9.2.10]

i. Provider/Subcontractor certifies that it and its affiliates are not delinquent in the payment of any debt to the State (or if delinquent has entered into a deferred payment plan to pay the debt), and Provider/Subcontractor and its affiliates acknowledge that the State may declare the Agreement void if this certification is false (30 ILCS 500/50-11) or if Provider/Subcontractor or an affiliate later becomes delinquent and has not entered into a deferred payment plan to pay off the debt (30 ILCS 500/50-60). [ICP Contract § 9.2.11; FHP-ACA Contract § 9.2.11; MLTSS Contract § 9.2.11]

j. Provider/Subcontractor certifies that it and its affiliates shall collect and remit Illinois Use Tax on all sales of tangible personal property into the State in accordance with provisions of the Illinois Use Tax Act (30 ILCS 500/50-12) and acknowledges that failure to comply can result in the Agreement being declared void. [ICP Contract § 9.2.12; FHP-ACA Contract § 9.2.12; MLTSS Contract § 9.2.12]

k. Provider/Subcontractor certifies that it has not been found by a court or the Pollution Control Board to have committed a willful or knowing violation of the Environmental Protection Act within the last five (5) years, and is therefore not barred from being awarded a contract (30 ILCS 500/50-14). [ICP Contract § 9.2.13; FHP-ACA Contract § 9.2.13; MLTSS Contract § 9.2.13]

l. Provider/Subcontractor certifies that it has not paid any money or valuable thing to induce any person to refrain from bidding on a State contract, nor has Provider/Subcontractor accepted any money or other valuable thing, or acted upon the promise of same, for not bidding on a

State contract (30 ILCS 500/50-25). [ICP Contract § 9.2.14; FHP-ACA Contract § 9.2.14; MLTSS Contract § 9.2.14]

m. Provider/Subcontractor certifies that it is not in violation of the "Revolving Door" section of the Illinois Procurement Code (30 ILCS 500/50-30). [ICP Contract § 9.2.15; FHP-ACA Contract § 9.2.15; MLTSS Contract § 9.2.15]

n. Provider/Subcontractor certifies that it has not retained a person to attempt to influence the outcome of a procurement decision for compensation contingent in whole or in part upon the decision or procurement (30 ILCS 500/50-38). [ICP Contract § 9.2.16; FHP-ACA Contract § 9.2.16; MLTSS Contract § 9.2.16]

o. Provider/Subcontractor certifies that it will report to the Illinois Attorney General and the Chief Procurement Officer any suspected collusion or other anti-competitive practice among any bidders, offerors, contractors, proposers, or employees of the State (30 ILCS 500/50-40, 50-45, 50-50). [ICP Contract § 9.2.17; FHP-ACA Contract § 9.2.17; MLTSS Contract § 9.2.17]

p. In accordance with the Steel Products Procurement Act, Provider/Subcontractor certifies that steel products used or supplied in the performance of a contract for public works shall be manufactured or produced in the United States, unless the executive head of the procuring agency grants an exception (30 ILCS 565). [ICP Contract § 9.2.18; FHP-ACA Contract § 9.2.18; MLTSS Contract § 9.2.18]

q. If Provider/Subcontractor employs twenty-five (25) or more employees, Provider/Subcontractor certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580). [ICP Contract § 9.2.19; FHP-ACA Contract § 9.2.19; MLTSS Contract § 9.2.19]

r. Provider/Subcontractor certifies that neither Provider/Subcontractor nor any substantially owned affiliate of Provider/Subcontractor is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce (30 ILCS 582). [ICP Contract § 9.2.20; FHP-ACA Contract § 9.2.20; MLTSS Contract § 9.2.20]

s. Provider/Subcontractor certifies that it has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33E-3, E-4). [ICP Contract § 9.2.21; FHP-ACA Contract § 9.2.21; MLTSS Contract § 9.2.21]

t. Provider/Subcontractor certifies that it complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105). [ICP Contract § 9.2.22; FHP-ACA Contract § 9.2.22; MLTSS Contract § 9.2.22]

u. Provider/Subcontractor certifies that it does not pay dues to or reimburse or subsidize payments by its employees for any dues or fees to any "discriminatory club" (775 ILCS 25/2). [ICP Contract § 9.2.23; FHP-ACA Contract § 9.2.23; MLTSS Contract § 9.2.23]

v. Provider/Subcontractor certifies that it complies with the State Prohibition of Goods from Forced Labor Act, and certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Agreement have been or will be produced in whole or in part by forced labor, or indentured labor under penal sanction (30 ILCS 583). [ICP Contract § 9.2.24; FHP-ACA Contract § 9.2.24; MLTSS Contract § 9.2.24]

w. Provider/Subcontractor certifies that no foreign-made equipment, materials, or supplies furnished to the State under the Agreement have been produced in whole or in part by the labor or any child under the age of twelve (30 ILCS 584). [ICP Contract § 9.2.25; FHP-ACA Contract § 9.2.25; MLTSS Contract § 9.2.25]

x. Provider/Subcontractor certifies that it is not in violation of Section 50-14.5 of the Illinois Procurement Code (30 ILCS 500/50-14.5), which states: "Owners of residential buildings who have committed a willful or knowing violation of the Lead Poisoning Prevention Act (410 ILCS 45) are prohibited from doing business with the State until the violation is mitigated." [ICP Contract § 9.2.26; FHP-ACA Contract § 9.2.26; MLTSS Contract § 9.2.26]

y. Provider/Subcontractor warrants and certifies that it and, to the best of its knowledge, its subcontractors, downstream entities, or related entities, have and will comply with Executive Order No. 1 (2007). That Order generally prohibits contractors and subcontractors from hiring the then-serving Illinois Governor's family members to lobby procurement activities of the State, or any other unit of government in the State including local governments if that procurement may result in a contract valued at over $25,000. This prohibition also applies to hiring for that same purpose any former State employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity. [ICP Contract § 9.2.27; FHP-ACA Contract § 9.2.27; MLTSS Contract § 9.2.27]

z. Provider/Subcontractor certifies that information technology, including electronic information, software, systems, and equipment developed or provided under the Agreement will comply with the applicable requirements of the Illinois Information Technology Accessibility Act Standards as published at www.dhs.state.il.us/iitaa (30 ILCS 587). [ICP Contract § 9.2.28; FHP-ACA Contract § 9.2.28; MLTSS Contract § 9.2.28]

aa. Provider/Subcontractor certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal or State department or agency, and is not currently barred or suspended from contracting with the State under Section 50-35(f), 50-35(g) or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 *et seq.* If at any time during the term of the Agreement, Provider/Subcontractor becomes barred, suspended, or excluded from participation in this transaction, Provider/Subcontractor shall, within thirty (30) days after becoming barred, suspended, or excluded, provide to HFS a written description of each offense causing the exclusion, the date(s) of the offense(s), the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence completed. [ICP Contract § 9.2.29; FHP-ACA Contract § 9.2.29; MLTSS Contract § 9.2.29]

bb. Provider/Subcontractor certifies that neither Provider/Subcontractor, nor any party directly or indirectly affiliated with Provider/Subcontractor, including but not limited to

Provider/Subcontractor's officers, directors, employees, and subcontractors, and the officers, directors, and employees of Provider/Subcontractor's subcontractors, shall have or acquire any Conflict of Interest (as defined below) in performance of the Agreement. Provider/Subcontractor shall disclose in writing any Conflicts of Interest to HFS no later than seven (7) days after learning of the Conflict of Interest. HFS may initiate any inquiry as to the existence of a Conflict of Interest, and Provider/Subcontractor shall cooperate with all such inquiries. HFS shall determine, in its sole discretion, whether a Conflict of Interest exists or whether Provider/Subcontractor failed to make any required disclosure. If HFS concludes that a Conflict of Interest exists, or that Provider/Subcontractor failed to disclose any Conflict of Interest, HFS may impose one or more remedies in its sole discretion, including without limitation the elimination of the Conflict of Interest or the non-renewal or termination of the Agreement. [ICP Contract § 9.2.30; FHP-ACA Contract § 9.2.30; MLTSS Contract § 9.2.30]

i. For purposes of this provision, "Conflict of Interest" shall mean an interest of Provider/Subcontractor, or any entity described above, which may be direct or indirect, professional, personal, financial, or beneficial in nature that, in the sole discretion of HFS, compromises, appears to compromise, or gives the appearance of impropriety with regard to Provider/Subcontractor's duties and responsibilities under the Agreement. This term shall include potential Conflicts of Interest. A Conflict of Interest may exist even if no unethical or improper act results from it or may arise where Provider/Subcontractor becomes a party to any litigation, investigation, or transaction that materially impacts Provider/Subcontractor's ability to perform under the Agreement. Any situation where Provider/Subcontractor's role under the Agreement competes with Provider/Subcontractor's professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable individual, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur, or that gives the appearance of the existence of bias or improper conduct, is a Conflict of Interest. [ICP Contract § 9.2.30.1; FHP-ACA Contract § 9.2.30.1; MLTSS Contract § 9.2.30.1]

cc. Provider/Subcontractor certifies that it is in compliance with all applicable standards, orders, or regulations issued pursuant to the federal Clean Air Act (42 U.S.C. § 7401 *et seq.*) and the federal Water Pollution Control Act (33 U.S.C. § 1251 *et seq.*). Violations shall be reported to the United States Department of Health and Human Services and the appropriate Regional Office of the United States Environmental Protection Agency. [ICP Contract § 9.2.31; FHP-ACA Contract § 9.2.31; MLTSS Contract § 9.2.31]

dd. Provider/Subcontractor certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of Provider/Subcontractor, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, Provider/Subcontractor shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such form is to be obtained at Provider/Subcontractor's request from the HFS Bureau of Fiscal Operations. Provider/Subcontractor shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when the Agreement was executed. Submission of this certification is a

prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure. [ICP Contract § 9.2.32; FHP-ACA Contract § 9.2.32; MLTSS Contract § 9.2.32]

ee. Provider/Subcontractor certifies that it has read, understands, and is in compliance with the registration requirements of the Elections Code (10 ILCS 5/9-35) and the restrictions on making political contributions and related requirements of the Illinois Procurement Code (30 ILCS 500/20-160 and 50-37). Provider/Subcontractor will not make a political contribution that will violate these requirements, which are effective for the duration of the term of office of the incumbent State governor or for a period of two (2) years after the end of the Agreement's term, whichever is longer. Provider/Subcontractor will certify, as applicable, either that it is not required to register as a business entity with the State Board of Elections, or has registered with the State Board of Elections and will appropriately and timely update that registration. [ICP Contract § 9.2.33 & Attachment X; FHP-ACA Contract § 9.2.33 & Attachment X; MLTSS Contract § 9.2.33 & Attachment X]

Exhibit B-10

Addendum Governing

Medicare-Medicaid Dual-Eligible Services

(Aetna Better Health of Illinois)

This Addendum Governing Medicare-Medicaid Dual-Eligible Services (the "Duals Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under, as well as the provision of any administrative or health-benefit management services/functions that relate to:

(6) the *Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services, In Partnership with the State of Illinois Department of Healthcare and Family Services and Aetna Better Health Inc.*, issued on August 10, 2016 (the "Three-Way Contract"); and

(7) any predecessor or successor contracts to, or amendments of, any of the foregoing;

to the extent that the terms and conditions of this Duals Addendum are applicable to Provider's services and obligations under the Agreement. The Three-Way Contract governs the program known as the Illinois Medicare-Medicaid Alignment Initiative a/k/a the MMAI (the "MMAI" or "Demonstration"), under which Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois ("Company") serves as a managed care organization.

This Duals Addendum is incorporated by reference into the Agreement between Company (or its affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing the Agreement, as identified on the first page of the Agreement (the "Provider"), and Provider must comply with the requirements set forth herein to the extent applicable to the services vendor performs under the Agreement. Note that this Duals Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement, in the Three-Way Contract, and in the policies, procedures, and provider manual of Company (or its affiliate, as the case may be). This Duals Addendum and the Agreement may be revised as directed by the State of Illinois (the "State") and/or by the Centers for Medicare and Medicaid Services ("CMS").

For purposes of this Duals Addendum, Company may be referred to as "MCO" or "the MCO" (a/k/a managed care organization), and the individuals who are enrolled with Company under the MMAI may be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Duals Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Duals 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 Duals

Addendum will govern and control with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and/or the MMAI; provided, however, that if there is any conflict between any of the terms of the Agreement, including this Duals Addendum, and the Three-Way Contract, then the terms of the Three-Way Contract will govern and control. Except as provided herein, all other provisions of the Agreement not inconsistent with this Duals Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Duals Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Three-Way Contract and the remainder of the Agreement.

. Provider furthermore represents and warrants that, with respect to all such aforementioned individuals and/or entities: (a) Provider's contracts therewith shall be in writing and shall specify, as applicable, the delegated activities and reporting responsibilities of those individuals and/or entities; (b) Provider shall cause those individuals and/or entities to comply with this Duals Addendum, including the Medicare Services Exhibit to the Agreement, and with all applicable State and federal laws and regulations (including applicable CMS instructions and directives), to the extent applicable to the services that those individuals and/or entities actually provide; and (c) Provider either has the authority to bind those individuals and/or entities in that regard (and shall provide written evidence of same to MCO upon request), or shall include in Provider's contracts with such individuals and/or entities all of the contractual and legal obligations and duties imposed upon Provider in the Agreement in order for such individuals and/or entities to comply with applicable State and federal laws and regulations, including applicable CMS instructions and directives (and again Provider shall provide written evidence of same to MCO upon request). This includes any such aforementioned individuals and/or entities that may perform services under the Agreement in Provider's offices, on behalf of Provider, for which Provider bills such services under the Agreement. To the extent that the State and/or CMS requires additional provisions to be included in Provider's contracts with such aforementioned individuals and/or entities, Provider shall amend its contracts in conformance therewith. [42 C.F.R. § 422.504]

All provisions of this Duals Addendum that by their nature should survive termination of the Agreement and/or termination of Provider's provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, or, as the case may be, Provider's provision of administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract and the Demonstration, shall survive such termination.

To the extent applicable to the services performed by vendor under the Agreement, the parties agree as follows:

REQUIREMENTS FOR THE MMAI

D. Illinois State Requirements

The State of Illinois requires that specific terms and conditions be incorporated into the Agreement. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the following requirements with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way

Contract and the MMAI:

3. Hold Harmless of Enrollees. Provider agrees that in no event, including but not limited to the nonpayment by Company of amounts due to Provider under the Agreement, the insolvency of Company, or any breach of the Agreement by Company, shall Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against the Member or persons acting on the Member's behalf (other than Company) for services provided pursuant to the Agreement except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Members and all persons acting on the Members' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf (other than Company). [215 ILCS 125/2-8(a)]

4. Quality Assurance. Provider shall provide, arrange for, or participate in the quality-assurance programs mandated by the Illinois Health Maintenance Organization Act, unless the Illinois Department of Public Health has certified that such programs will be fully implemented without any participation or action from Provider. [215 ILCS 125/2-8(a); 50 Ill. Admin. Code § 5241.50(a)(4)]

5. Termination of Agreement. Notwithstanding anything in the Agreement to the contrary, if either Company or Provider seeks (i) to terminate the Agreement "with cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least sixty (60) days' written notice to the other party; or (ii) to terminate the Agreement "without cause" (as that term is used and defined in the Agreement), the terminating party shall provide at least ninety (90) days' written notice to the other party. Furthermore, Provider shall cooperate with Company with respect to Company's obligation to provide timely notice to Enrollees of any termination that would curtail or eliminate services to such Enrollees, with such notice to be sent (i) at least sixty (60) days prior to that termination, or (ii) immediately, if Company receives less than sixty (60) days' notice of that termination from Provider. The notice to be sent to Enrollees shall include instructions regarding referrals that have previously been issued and appointments that may be pending. [50 Ill. Admin. Code § 5241.50(a)(5)–(6); 305 ILCS 5/5F-40(a)]

6. No Discrimination. Provider will not discriminate against Enrollees or potential Enrollees on the basis of payment source. [77 Ill. Admin. Code § 240.50(d)(4)]

7. Anti-Gag Clause; Prohibition on Retaliation. Provider shall not be prohibited or otherwise restricted or discouraged from, and shall not prohibit or otherwise restrict or discourage its downstream providers or subcontractors from, taking any of the following actions so long as those actions are within the lawful scope of the acting party's practice: (a) advocating for medically appropriate health care services for Enrollees, which may include without limitation appealing denials and protesting decisions, policies, and practices; and/or (b) discussing with Enrollees, prospective Enrollees, or the public any health care services, health care providers, utilization review policies, quality assurance policies, or terms and conditions of plans and plan policy. Furthermore, Company shall not retaliate against Provider, and Provider shall not retaliate against its downstream providers or subcontractors, for any of the foregoing actions. Notwithstanding the foregoing, nothing in this provision shall be construed to prohibit: (a) Company or Provider from making a determination not to pay for a particular health care service, from enforcing reasonable peer review or utilization review protocols, or from determining whether a physician or other health care provider has complied with those protocols; and/or (b) a Provider that is a hospital from taking disciplinary actions against a physician as authorized by law. [215 ILCS 134/30(a); 215 ILCS 134/35(a)–(d)]

8. Cooperation with Company. Provider shall cooperate with Company with respect to Company's

obligations and responsibilities relating to the "HMO self-evaluation structure" and associated activities set forth in 77 Ill. Admin. Code § 240.60. [77 Ill. Admin. Code § 240.50(d)(1)(C)]

9. Pharmacy Benefits. Company and Provider shall not permit or allow, whether by contract, written policy, or procedure, any individual or entity to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act (codified at 410 ILCS 620/3.14). [215 ILCS 134/30(b)]

10. Use of Hospitalists. Neither Company nor Provider shall require or otherwise mandate, whether by contract, written policy, or procedure, any Enrollee to substitute his or her participating primary care provider (PCP) during inpatient hospitalization, such as with a hospitalist physician, without the agreement of that Enrollee's participating primary care provider (PCP). Company and Provider (if applicable) shall inform Enrollees of any policies, recommendations, or guidelines concerning the substitution of the Enrollee's primary care provider (PCP) when hospitalization is necessary in the manner set forth in 215 ILCS 5/15(d)–(e). [215 ILCS 134/30(c)]

11. No Transfer of Liability to Downstream Providers. Neither Company nor Provider shall transfer or attempt to transfer to any health care provider, by indemnification, hold harmless, or contribution requirements that are set forth in any contract, written policy, or procedure, any liability relating to activities, actions, or omissions of Company and/or Provider or their respective officers, employees, or agents; provided, however that nothing in this provision shall relieve any health care provider from liability for his, her, or its own negligence in the performance of his, her, or its duties arising from treatment of an Enrollee. [215 ILCS 134/95]

12. Medical Records. With respect to Enrollee medical records:

a. Provider shall maintain Enrollee medical records in a timely, legible, accurate, current, complete, and organized manner, with appropriate dates and identification and initialing/signature of the Provider, to facilitate retrieval and compilation of records and to ensure Enrollee continuity of care. For each encounter or episode of care that Provider has with an Enrollee, Provider shall place the following information into the Enrollee's medical records: (1) the reason for the encounter; (2) evidence of the Provider's assessment of the Enrollee's health problems; (3) current diagnosis of the Enrollee, including the results of any diagnostic tests; (4) the plan of treatment, including any therapies and health education; (5) any medical history relevant to the current episode of care; and (6) confirmation that all outcomes of ancillary reports, such as laboratory tests and x-rays, have been reviewed by the individual or entity who ordered the reports and that follow-up actions have been taken regarding report results that are deemed significant by the individual or entity who ordered those reports. [77 Ill. Admin. Code §§ 240.50(c)(1), 240.90(a)–(b)]

b. If Provider is an Enrollee's primary care provider (PCP), Provider shall furthermore maintain an Enrollee medical record that contains, with respect to each routine, scheduled appointment with that primary care provider (PCP): (1) identification; (2) patient history; (3) known past surgical procedures; (4) known past and current diagnoses and problems; and (5) known allergies and untoward reactions to drugs. [77 Ill. Admin. Code § 240.90(c)]

13. Capitated Contracts. If Company compensates Provider under the Agreement on a capitated basis for furnishing, arranging, or providing health care services:

a. Provider agrees that in no event, including but not limited to nonpayment by Company of amounts due to Provider under the Agreement, insolvency of Company, or any breach of the Agreement by Company, shall Provider or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Member or persons acting on the

Member's behalf (other than Company) for services provided pursuant to the Agreement, except for the payment of applicable copayments or deductibles for services covered by Company or fees for services not covered by Company. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Company's Members and persons acting on the Members' behalf (other than Company) shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf (other than Company). [50 Ill. Admin. Code § 5241.50(e)]

b. If Provider is a "Managed Care Organization" as that term is defined in 50 Ill. Admin. Code § 5241.20, Provider shall submit to Company copies of Provider's quarterly financial statements, which shall include Provider's balance sheet and statements of income and cash flow within forty-five (45) days after the end of each fiscal period. In addition, Provider shall submit, within ninety (90) days after the end of Provider's fiscal year, copies of Provider's audited annual financial statements prepared in accordance with generally accepted accounting principles, if available. Provider acknowledges and agrees that the Illinois Department for Healthcare and Family Services ("HFS"), at its discretion, may require Company to submit for HFS's inspection the financial statements that Company has received from Provider (which such financial statements shall be deemed confidential by HFS). Provider agrees to fully cooperate with, and disclose all relevant information requested by, Company's actuaries for the preparation of such actuaries' opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16. Company acknowledges that in the event of Provider's insolvency, Company is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Company's Enrollees. [50 Ill. Admin Code §5241.50(d)] For purposes of this provision, "Managed Care Organization" or "MCO" means a partnership, association, corporation, or other legal entity, including but not limited to individual practice associations (IPAs) and physician hospital organizations (PHOs), that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services. [50 Ill. Admin. Code § 5241.20]

E. Medicare Requirements

Without limiting any obligation of Provider under the Agreement, Provider shall comply with, and shall cause its Downstream Entities to comply with, the requirements set forth in this **Section B** (including any delegated function-specific Schedules appended hereto) and the Medicare Services Exhibit to the Agreement (the "Medicare Services Exhibit") with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider), as applicable, that relate to those Covered Services or to the Three-Way Contract and the Demonstration (the "Medicare Services"). The term "Downstream Entities" shall have the meaning that is ascribed to it in the Medicare Services Exhibit. Furthermore, with respect to the requirements set forth in this **Section B**: (a) the term "Provider" shall include Provider's permanent and temporary employees; (b) the Members who are dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration shall collectively be referred to as the "Medicare Members"; and (c) the managed-care plan that MCO offers under the Three-Way Contract and the Demonstration shall be referred to as the "Medicare Plan." Provider furthermore acknowledges and agrees that all terms of the Medicare Services Exhibit hereto shall apply equally to services provided in connection with the Three-Way Contract and the Demonstration, even if the Medicare Services Exhibit only refers to Medicare Advantage products. The requirements set forth in this **Section B** (including the Medicare Services Exhibit) shall be governed by federal laws, regulations, and agency requirements that are applicable to the Medicare program. In the event that changes to such governing laws, regulations, or agency requirements occur, the new law, regulation, or agency requirement that is applicable to the Medicare program shall supersede to the extent required by any such later required changes.

Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. PROVIDER OBLIGATIONS.

Q. Compliance; Cooperation. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement, including without limitation any activities and responsibilities that MCO is delegating to Provider in connection with the Three-Way Contract and the Demonstration, will be performed consistent with and will comply with MCO's contractual and legal obligations and duties imposed on MCO under the Three-Way Contract and under applicable Medicare laws, regulations, rules, and other directions of CMS. Upon request, Provider shall immediately provide to MCO any information that is required by MCO to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. Provider agrees to cooperate with and participate in internal and external review procedures necessary to allow MCO to process Medicare appeals and grievances in accordance with Medicare laws, regulations, and CMS instructions. [42 C.F.R. § 422.504(i)(3)(iii)]

R. Compliance Program and Anti-Fraud Initiatives. Provider shall (and shall cause its Downstream Entities, if any, 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 the Medicare Plan. Such compliance program shall be appropriate to the organization and operations of Provider and Provider's Downstream Entities and shall include:

(6) Written compliance policies and standards of conduct that are comparable to Aetna's compliance policies/Aetna Code of Conduct and articulate the entity's commitment to comply with federal and state laws, ethical behavior, and compliance program operations. Provider will disseminate either Aetna's compliance policies/Aetna Code of Conduct or comparable versions to Provider's employees, officers, and Downstream Entities within ninety (90) days of hire/contracting, when updates are made, and annually thereafter.

(7) Reporting mechanisms communicated to Provider's employees and Downstream Entities for their use in adhering to the expectation that Provider, its employees, and its Downstream Entities report potential non-compliance or FWA issues (internally and to MCO, as applicable) and understand their obligation to report. Provider must publicize the reporting methods to Provider employees and Downstream Entities along with a no-tolerance policy for retaliation or retribution for good-faith reporting.

(8) Completion of CMS's Medicare Learning Network® "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training" by Provider employees, officers, and Downstream Entities initially within ninety (90) days of hire/contracting and at least annually thereafter, unless exempt from such training under relevant CMS regulations. Training may be completed in one of two ways: (1) by completing the general compliance and FWA training modules located on the CMS Medicare Learning Network; or (2) by downloading, viewing or printing the content of the then current CMS standardized training modules from the CMS website to incorporate into Provider's and/or Downstream Entity's organization's existing compliance training materials/systems. The CMS training content may not be changed but Provider and/or its Downstream Entities may add to it to cover topics specific to its organization.

(9) Processes to oversee and ensure that Provider and Provider's Downstream Entities maintain compliance with processes to oversee and ensure that: (1) Provider and Provider's Downstream Entities maintain compliance with CMS compliance program requirements, and (2) Provider's Downstream Entities perform Medicare Services consistent with this Agreement and the agreement between Provider and such Downstream Entities. Provider's oversight under this Agreement shall include: (1) imposition of disciplinary actions, as needed, to ensure employee compliance with CMS compliance program requirements, and (2) implementation of corrective actions (up to and including contract termination), as needed, with respect to its Downstream Entities to ensure Downstream Entity compliance with applicable CMS requirements, including the CMS compliance program requirements, this Agreement, and Provider's contract with the Downstream Entity.

(10) Retention of evidence showing that Provider and Provider's Downstream Entities complied with the requirements set forth in this Section. Such evidence must be maintained for at least the period of time specified in Section B.1.F. hereof and shall be made available to MCO and CMS, upon request. Provider shall complete attestations in the form and manner requested by Company to confirm its compliance with this section on an annual basis.

[Chapter 21 of the Medicare Managed Care Manual]

S. Federal Fund Obligations. Provider understands and agrees that payments received by MCO for the Medicare Plan from CMS pursuant to the Three-Way Contract, as well as payments that Provider receives from MCO for performing services and functions under the Agreement, constitute the receipt of federal funds. As a result, Provider, by entering into the Agreement and the terms of this Duals 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. [Section 120 of Chapter 11 of the Medicare Managed Care Manual]

T. Continuation of Services. In the event the Three-Way Contract terminates or MCO becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized 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 the Agreement, regardless of the reason for termination, including the insolvency of MCO, and shall supersede any oral or written agreement between Provider and a Medicare Member. [42 C.F.R. § 422.504(g)(2)(i) and (ii)]

U. Policies, Programs & Procedures. Provider agrees to comply with MCO's policies and procedures (which MCO shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Duals Addendum, and the Three-Way Contract and Demonstration. Provider agrees to comply with MCO's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies MCO may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that an MCO 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. [Section 100.4 of Chapter 11 of the Medicare Managed Care Manual]

V. Maintenance of Records. Provider, on behalf of itself and its Downstream Entities (if any), shall preserve records applicable to Medicare Members and/or to MCO's participation in the Three-Way

Contract and Demonstration, for the longer of: (i) the period of time required by state and federal law, or (ii) ten (10) years. 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, if any, containing data used by MCO to calculate Medicare medical loss ratios ("MLRs") for MCO's Medicare products and/or evidence needed by MCO 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 MCO to CMS. This provision shall survive the termination of the Agreement, regardless of the cause of termination. [42 C.F.R. § 422.504(i)(2)(i)(ii) and 42 C.F.R. § 422.2480(c)(1)]

W. Contracts with Excluded Entities. Provider understands and agrees that no person or entity that provides Medicare Services, directly or indirectly, for MCO's Medicare Plan, may be an individual or entity excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person or entity will be employed by or utilized by Provider or by any of Provider's Downstream Entities to directly or indirectly perform Medicare Services under this Agreement. 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 Services Administration System for Awards Management (collectively, "Exclusion Lists") to ensure that no persons or entities employed by or utilized by Provider or by any of Provider's Downstream Entities are included on such Exclusion Lists. Provider agrees to review the Exclusion Lists prior to initially hiring, appointing, or contracting with any new employee, temporary employee, or Downstream Entity, and at least once per month thereafter to confirm that such persons and entities are not included on such Exclusion Lists. Provider agrees that if any such person or entity utilized by Provider to directly or indirectly perform Medicare Services under this Agreement appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Provider will immediately remove the employee, temporary employee, or Downstream Entity from any work related directly or indirectly to MCO's Medicare Plan, and take all corrective actions required under applicable laws, rules, or regulations. In the event Provider or any employee, temporary employee, or Downstream Entity of Provider that directly or indirectly performs Medicare Services under this Agreement is listed in an Exclusion List after the Effective Date of this Duals Addendum, MCO shall have the right, in its sole discretion and judgment, to terminate Provider's participation in MCO's Medicare Plan in accordance with the Agreement or to disqualify any such person or entity on the Exclusion List from providing any part of the Medicare Services. [42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6) & 1001.1901 and Section 50.6.8 of the Medicare Managed Care Manual]

X. Offshore Services. Provider is prohibited from performing, and is prohibited from engaging or paying any individual or entity to perform, any services for the Medicare Plan if Provider or such individual or entity, as the case may be, 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 MCO, in its sole discretion and judgment, agrees in advance and in writing to the provision of such Offshore Services by Provider and/or such individual or entity. Provider furthermore agrees that MCO has the right to audit Provider and/or such individual or entity prior to the provision of Offshore Services for the Medicare Plan. Additionally, Provider represents and warrants that it does not and will not permit any Medicare Member's protected health information (PHI), or any other information that MCO or Provider has obtained in connection with the Three-Way Contract and Demonstration, to be accessible by any individual or entity that is physically located outside of one of the fifty United States or one of the United States Territories without prior written notice to MCO and without MCO's prior written approval of same. In the event that MCO agrees in advance and in writing to the provision of Offshore Services that involve Medicare Member protected health information (PHI), such Offshore Services are subject to CMS reporting within thirty (30) days of: (1) performing, or contracting to perform, such Offshore Services, and (2) any time Provider changes the Offshore Services being performed. [CMS Memo dated July 23, 2007 on "Sponsor Activities Performed Outside of the United States" and CMS Questions and Answers dated September 20, 2007 on "Sponsor Activities Performed Outside of the United States"]

Y. Submission of Encounter Data. Provider hereby acknowledges that MCO 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 MCO and to provide MCO with all such information in such form and manner as requested by MCO. Provider agrees to immediately notify MCO if any encounter data that Provider submitted to MCO for Medicare Members is inaccurate, incomplete, or erroneous, and to cooperate with MCO to correct erroneous encounter data to ensure MCO's compliance with Medicare laws, rules, and regulations and CMS instructions. [42 C.F.R. § 422.310]

Z. Certification of Data. Provider recognizes that MCO 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 MCO by its contracted providers and Downstream Entities. To the extent that Provider generates and/or compiles and provides to Company (either on its own or through its Downstream Entities) any data that MCO, in turn, submits to CMS, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete, and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by MCO. [42 C.F.R. § 422.504(l)(3)]

AA. Medicare Member Complaints. Provider agrees to cooperate with MCO in resolving any Medicare Member complaints related to coverage or the provision of Covered Services. MCO 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 MCO in the required time. Provider shall use best efforts to resolve complaints in a fair and equitable manner. [42 C.F.R. § 422.562(a)]

BB. Enrollment as Medicare Provider. To the extent that Provider prescribes drugs covered under Medicare Part D to Medicare Members who have Medicare prescription drug ("MA-PD") coverage offered by MCO, Provider agrees to comply with the requirements set forth in 42 C.F.R. § 423.120(c)(6), including without limitation the requirement that Provider be enrolled in Medicare in an approved status in order for its prescriptions to be covered under Medicare Part D. [42 C.F.R. § 423.120(c)(6)]

CC. Home Infusion Drugs. The following provisions shall only apply to Provider if Provider dispenses to a Medicare Member home infusion drugs that are covered under Medicare Part D and the Medicare Member has MA-PD coverage offered by MCO ("Home Infusion Drug"):

12. With respect to Home Infusion Drugs, MCO will pay clean claims (as defined in 42 C.F.R. § 423.520(b)) submitted by Provider on behalf of Medicare Members within 14 days for electronic claims and within 30 days for claims submitted otherwise. [42 C.F.R. § 423.505(i)(3)(vi)]

13. Home Infusion Drugs will be reimbursed (as applicable) in accordance with a fee schedule, or the third-party pricing source (*e.g.*, Medi-Span) otherwise agreed upon as set forth in the Agreement or Provider's agreement with MCO's Pharmacy Benefit Manager ("PBM"). [42 C.F.R. § 423.505(i)(3)(viii)(B)]

14. If a prescription drug pricing standard is used for reimbursement of Home Infusion Drugs, updates to such a standard will occur not less frequently than once every 7 days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the Home Infusion Drug. [42 C.F.R. § 423.505(i)(3)(viii)(A)]

15. In accordance 42 C.F.R.§ 423.120(c)(3), Provider agrees to submit claims for Home Infusion Drugs to MCO or its PBM whenever the Medicare Member's ID card is presented or is on file at the Provider, unless the Medicare Member expressly requests that the claim not be submitted to MCO or its PBM. [42 C.F.R.§ 423.120(c)(3)]

16. Provider must submit claims for Home Infusion Drugs in real time by means of point of service claims adjudication systems in compliance with CMS standards. [42 C.F.R. § 423.505(b)(17)]

17. Provider must provide Medicare Members with access to the negotiated prices (as defined in 42 C.F.R. § 423.100) for Home Infusion Drugs to Members. [42 C.F.R. § 423.104(g)(1)]

18. Provider must charge/apply the correct cost-sharing amount to the Medicare Member for Home Infusion Drugs. [42 C.F.R. § 423.104]

19. At the time of purchase by a Medicare Member, Provider must inform the Medicare Member of any differential between the price of the Home Infusion Drug being dispensed and the price of the lowest priced generic version of that Home Infusion Drug available from Provider, unless the Home Infusion Drug being dispensed is the lowest priced generic version of that Home Infusion Drug. [42 C.F.R. § 423.132]

20. Provider agrees to ensure that the professional services and ancillary supplies necessary for Home Infusion Drugs are in place before dispensing Home Infusion Drugs to a Medicare Member in his/her place of residence. [42 C.F.R. § 423.120(a)(4)(iii)]

21. Provider agrees to provide delivery of Home Infusion Drugs within 24 hours of a Medicare Member's discharge from an acute setting, or later if so prescribed. [42 C.F.R. § 423.120(a)(4)(iv)]

22. Provider shall submit to MCO (not PBM) claims for equipment, supplies, and professional services associated with Home Infusion Drugs dispensed by Provider to a Medicare Member that are covered under Medicare Part C.

DD. Marketing. Consistent with federal laws, regulations, and agency requirements applicable to the Medicare program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare Members, 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. [2017 Medicare Marketing Guidelines, as amended from time to time]

EE. Non-Covered Services. Provider shall not hold a Medicare Member financially responsible for payment of a service not covered under the MCO's Medicare Plan ("Non-Covered Service") unless the Medicare Member has received a pre-service organization determination notice of denial from MCO before such services are rendered. Provider acknowledges and agrees that if Provider renders Non-Covered Services to a Medicare Member who has not received a pre-service organization determination notice of denial from MCO, the Provider must hold the Medicare Member harmless for the Non-Covered Services and cannot charge the Medicare Member any amount beyond the normal cost-sharing amounts (*i.e.*, copayments,

coinsurance, and/or deductibles). With respect to those Non-Covered Services that are clearly listed as exclusions under the MCO's Medicare Plan, a pre-service organization determination is not required in order for Provider to hold the Medicare Member financially liable for such Non-Covered Services. [CMS Memo dated May 5, 2014 "Improper Use of Advance Notices of Non-coverage"]

FF. Dual-Eligible Hold Harmless. Provider acknowledges and agrees that Medicare 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 furthermore agrees that it will not collect Cost Sharing Amounts from Medicare Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the MCO'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. [42 C.F.R. § 422.504(i)(3)(i)]

2. OTHER TERMS.

C. MCO shall not pay any amounts beyond the amounts set forth in the applicable Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement), 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. Furthermore, Provider and MCO each acknowledge and agree that payments under the Medicare program to providers, suppliers, and MCO 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, Provider and MCO agree that, in the event of a Medicare Payment Adjustment, MCO's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. MCO shall adjust payments under the Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjust payments to Provider for Covered Services until the earlier of (i) the discontinuation of the Medicare Payment Adjustment, or (ii) the replacement of the Medicare Payment Adjustment by a subsequent Medicare Payment Adjustment.

D. Pursuant to Section B.1.J. of this Duals Addendum, Provider certifies that the diagnosis codes submitted to MCO for Medicare Members that MCO is required to submit to CMS will be accurate, complete, and truthful (the "Certification"). Provider acknowledges and agrees that MCO may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to MCO 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, "diagnosis code" shall mean an International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) code or its successor.

F. Requirements Under the MMAI Three-Way Contract

The Three-Way Contract requires that specific additional terms and conditions be incorporated into the Agreement. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the requirements set forth in this **Section C** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract and the MMAI. With respect to the requirements set forth in this **Section C**, any capitalized terms that are used but not defined herein shall have the meanings that are ascribed to them in

the Three-Way Contract. Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

71. The delegated activities and reporting requirements for which Provider is responsible are contained in the Agreement. Provider shall ensure that it and its downstream and related entities perform all such delegated activities and reporting requirements in compliance with 42 C.F.R. §§ 422.504, 423.505, 438.6(l), and 438.230(b)(1), as applicable. [Appendix C, ¶ A of Three-Way Contract]

72. HHS, the Comptroller General, the State of Illinois Department of Healthcare and Family Services (the "Department"), the Department's Office of Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, and their designees, and other state and federal agencies with monitoring authority related to Medicare and Medicaid, have the right to audit, evaluate, and inspect any books, contracts, computer, or other electronic systems, including medical records and documentation, of Provider and its downstream and related entities, and the foregoing rights to inspect, evaluate, and audit any pertinent information for any particular contract period shall exist for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later. [Appendix C, ¶ B of Three-Way Contract]

73. Provider and its downstream and related entities shall not hold Enrollees liable for payment of any fees that are the obligation of MCO. [Appendix C, ¶ C.1 of Three-Way Contract]

74. Any services or other activity performed by Provider and/or its downstream and related entities shall be performed in accordance with the MCO's contractual obligations to CMS and the Department. [Appendix C, ¶ C.2 of Three-Way Contract]

75. MCO shall revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS, the Department, or the MCO determine that Provider and/or its downstream and related entities have not performed their delegated activities or reporting requirements satisfactorily. [Appendix C, ¶ C.4 of Three-Way Contract]

76. The performance of Provider and its downstream and related entities under the Agreement will be monitored by MCO on an ongoing basis and MCO may impose corrective action as necessary. [Appendix C, ¶ C.5 of Three-Way Contract]

77. Provider and its downstream and related entities agree to safeguard Enrollee privacy and confidentiality of Enrollee health records. [Appendix C, ¶ C.6 of Three-Way Contract]

78. Provider and its downstream and related entities must comply with all federal and state laws, regulations, and CMS instructions. [Appendix C, ¶ C.7 of Three-Way Contract]

79. To the extent that Provider and/or its downstream and related entities provide credentialing of medical providers under the Agreement:

A. The credentials of medical professionals affiliated with the Provider and/or its downstream and related entities will be reviewed by MCO; or

B. The credentialing process will be reviewed and approved by MCO and MCO shall audit the credentialing process on an ongoing basis.

[Appendix C, ¶ D of Three-Way Contract]

80. To the extent that MCO has delegated the selection of providers under the Agreement to Provider or its downstream and related entities, MCO retains the right to approve, suspend, or terminate that arrangement. [Appendix C, ¶ E of Three-Way Contract]

81. MCO has the right to terminate its contract with Provider with cause upon sixty (60) days' notice, and without cause upon 120 days' notice, and Provider shall assist with transitioning Enrollees to new providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the MCO or Enrollee. If a for-cause termination, MCO must have an internal grievance procedure that allows Provider to contest the grounds for the termination prior to the effective date of the termination. [Appendix C, ¶ F of Three-Way Contract]

82. MCO shall provide a written statement to Provider of the reason or reasons for termination for cause. [Appendix C, ¶ G of Three-Way Contract]

83. MCO is obligated to pay Provider under the terms of the Agreement, which includes a prompt-payment provision that has been developed and agreed to by both MCO and Provider. [Appendix C, ¶ H.1 of Three-Way Contract]

84. Provider and its downstream and related entities shall provide all services under the Agreement in a Culturally Competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds. [Appendix C, ¶ H.2 of Three-Way Contract]

85. Provider and its downstream and related entities shall abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. [Appendix C, ¶ H.3 of Three-Way Contract]

86. Provider and its downstream and related entities shall ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas. [Appendix C, ¶ H.4 of Three-Way Contract]

87. Provider and its downstream and related entities shall maintain Enrollee records and information in an accurate and timely manner. [Appendix C, ¶ H.5 of Three-Way Contract]

88. Provider and its downstream and related entities shall ensure timely access by Enrollees to the records and information that pertain to them. [Appendix C, ¶ H.6 of Three-Way Contract]

89. Provider and its downstream and related entities shall not hold Enrollees liable for Medicare Part A

and B cost sharing, and all Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees. [Appendix C, ¶ H.7 of Three-Way Contract]

90. Provider and its downstream and related entities shall ensure that their EMTALA obligations are fulfilled as required by law and the Agreement and must not create any conflicts with any hospital actions required to comply with EMTALA. [Appendix C, ¶ H.8 and Section 2.9.9.1 of Three-Way Contract]

91. Provider and its downstream and related entities, including without limitation all primary care providers, shall not close or otherwise limit acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees. [Appendix C, ¶ H.9 of Three-Way Contract]

92. MCO shall not refuse to contract or pay Provider for the provision of Covered Services solely because Provider has in good faith:

(a) Communicated with or advocated on behalf of one or more of the prospective, current, or former patients of Provider or its downstream and related entities regarding the provisions, terms, or requirements of the MCO's health benefit plans as they relate to the needs of such patients; or

(b) Communicated with one or more of the prospective, current, or former patients of Provider or its downstream and related entities with respect to the method by which such provider is compensated by the MCO for services provided to the patient.

[Appendix C, ¶ H.10 of Three-Way Contract]

93. Provider and its downstream and related entities are not required to indemnify MCO for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against MCO based on MCO's management decisions, utilization review provisions, or other policies, guidelines, or actions. [Appendix C, ¶ H.11 of Three-Way Contract]

94. Provider and its downstream and related entities shall comply with all MCO's requirements and MCO Policies for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services. [Appendix C, ¶ H.12 of Three-Way Contract]

95. MCO shall notify Provider in writing of modifications in payments, modifications in Covered Services or modifications in MCO's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 30 calendar days before the effective date of such modification unless such other date for notice is mutually agreed upon between MCO and Provider or unless such change is mandated by CMS or the Department without 30 calendar days' prior notice. [Appendix C, ¶ H.13 of Three-Way Contract]

96. Provider must comply with all Enrollee payment restrictions, including balance billing restrictions, and

MCO may revoke or impose other specified remedies against Provider if Provider does not comply with such provisions. [Appendix C, ¶ H.14 of Three-Way Contract]

97. Provider and its downstream and related entities shall not bill Enrollees for charges for Covered Services other than pharmacy co-payments, if applicable. [Appendix C, ¶ H.15 of Three-Way Contract]

98. No payment shall be made by MCO to Provider, and Provider shall not seek payment from MCO, for a Provider Preventable Condition as defined in 42 C.F.R. § 447.26(b), and Provider shall, as a condition of payment from MCO, comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by MCO and/or the Department. [Section 2.7.3.2 and Appendix C, ¶¶ H.16 and H.17 of Three-Way Contract]

99. To the extent Provider is a Primary Care Physician or a specialty provider, Provider shall ensure coverage for its practice twenty-four (24) hours a day, seven (7) days a week and have a published after-hours telephone number; voicemail alone after hours is not acceptable. [Section 2.9.2.1 and 2.10.4.1 of Three-Way Contract]

100. MCO shall monitor and ensure that all Utilization Management activities provided by Provider comply with all provisions of the Three-Way Contract, and Provider and its downstream and related entities shall cooperate with and utilize MCO's quality assurance program. [Section 2.13.2.1.2.2 and Appendix C, ¶ H.18 of Three-Way Contract]

101. Provider shall not bill Enrollees for missed appointments or refuse to provide services to Enrollees who have missed appointments. Providers must work with Enrollees and MCO to assist Enrollees in keeping their appointments. [Appendix C, ¶ H.19 of Three-Way Contract]

102. Provider shall not refuse to provide services to an Enrollee because the Enrollee has an outstanding debt with the Provider from a time prior to the Enrollee becoming a member. [Appendix C, ¶ H.20 of Three-Way Contract]

103. Provider shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. Contracts or arrangements with First Tier, Downstream and Related Entities shall not include incentive plans that include a specific payment to Provider or its downstream and related entities as an inducement to deny, reduce, delay, or limit specific, Medically Necessary Services, and (a) Provider and/or its downstream and related entities shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate, and (b) MCO shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate. Nothing herein shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared-risk agreements that are made with respect to physicians or physician groups or that are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services, and equipment provided or authorized by another physician or health care provider, comply with Paragraph 34 immediately below. [Appendix C, ¶¶ H.14 and I, and Section 5.1.7 of Three-Way Contract]

104. MCO shall not impose a financial risk on Provider or its downstream and related entities for the costs of medical care, services, or equipment provided or authorized by another Physician or health care provider unless such contract includes specific provisions with respect to the following:

C. Stop-loss protection;

D. Minimum patient population size for the Physician or Physician group; and

C. Identification of the healthcare services for which Physician or Physician group is at risk.

[Appendix C, ¶ J of Three-Way Contract]

105. All contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites that provide services must include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. [Appendix C, ¶ K of Three-Way Contract]

106. Nothing shall be construed to restrict or limit the rights of MCO to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious nonmedical providers. [Appendix C, ¶ L of Three-Way Contract]

107. Provider shall meet all terms and requirements of the Three-Way Contract that are applicable to Provider. [Section 2.7.2.2.1 of Three-Way Contract]

108. Provider will collaborate with MCO on documentation systems reporting, communications, policies, and any other matters necessary for any readiness review required under the Three-Way Contract. [Section 2.2.1 of Three-Way Contract]

109. Provider shall collaborate with MCO, as requested and required under the Three-Way Contract, on activities relating to Care Coordination and the Enrollee Care Plans. [Section 2.5 of Three-Way Contract]

110. As requested and required under the Three-Way Contract, Provider shall actively participate as a member of the Interdisciplinary Care Team, and shall collaborate with the Enrollee and other members of the Interdisciplinary Care Team to perform the functions and tasks that are required of the Interdisciplinary Care Team under the Three-Way Contract. [Section 2.5.2 of Three-Way Contract]

111. Provider must maintain locations that are accessible to Enrollees with disabilities and that are ADA compliant. [Section 2.8.1.4 of Three-Way Contract]

112. Provider shall be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollee with disabilities (both congenital and acquired disabilities), or other special population served by the MCO. [Section 2.7.1.6 of Three-Way Contract]

113. To the extent that Provider is multilingual, Provider shall understand and comply with its obligations

under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Provider to meet these obligations. [Section 2.7.1.8 of Three-Way Contract]

114. Provider shall maintain a strong understanding of disability culture and Long Term Supports and Services. [Section 2.7.1.14 of Three-Way Contract]

115. To the extent that Provider provides Medicare-covered services, Provider shall be enrolled as a Medicare provider in order to submit claims for reimbursement or otherwise participate in the Medicare program. To the extent that Provider provides Medicaid-covered services, Provider shall be enrolled in the Illinois Medicaid program, if such enrollment is required by the Department's rules or policy, in order to submit claims for reimbursement or otherwise participate in the Illinois Medicaid program. [Section 2.8.1.2 of Three-Way Contract]

116. If a Provider provides any Emergency Services to an Enrollee, the Provider must promptly notify the Enrollee's Primary Care Physician of the Enrollee's screening and treatment. [Section 2.9.8.1.7 of Three-Way Contract]

117. If any Grievance or Appeal is filed with Provider, Provider must immediately forward it to MCO. [Section 2.11.1.1 of Three-Way Contract]

118. Provider must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) as outlined in the Three-Way Contract, and must maintain capacity to deliver services in a manner that reasonably accommodates the needs of Enrollees. [Section 2.9.1.6 of Three-Way Contract]

119. Upon MCO's request, Providers must provide the following information: (a) its name, address, and telephone number; (b) its training in and experience treating, including any expertise in treating the MMAI population; (c) its office hours, including the name of any provider site open after 5:00 p.m. (Eastern Time) weekdays and/or open on weekends; (d) whether it has completed cultural competence training; (e) its licensing information; (f) whether it has specific accomodations for people with physical disabilities; (g) whether it is accepting new patients; (h) whether it is on a public-transportation route; (h) any languages other than English, including ASL, spoken by Provider or offered by skilled medical interpreters at Provider's site, and whether Provider has access to language line interpreters; (i) if Provider is a behavioral-health provider, its training in and experience treating trauma, child welfare, and substance abuse. [Section 2.14.5.2 of Three-Way Contract]

120. As requested and required, Provider must provide any information that CMS and/or the Department require (a) under the Three-Way Contract related to the performance of MCO's responsibilities, including non-medical information for the purposes of research and evaluation; (b) to comply with all applicable federal or state laws and regulations; and (c) for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Grievances and Appeals and enrollment/disenrollment rates. [Section 2.16.1 of Three-Way Contract]

121. Collaborate with MCO in the collection and maintenance of all Encounter Data for all Covered Services that Provider provides to Enrollees, ensuring that all such data can be linked to the Department eligibility data. [Section 2.17 of Three-Way Contract]

122. In connection with the MMAI, Provider shall act in an independent capacity and not as an officer, employee, or agent of the federal government or the State of Illinois. [Section 5.1.3.1 of Three-Way Contract]

123. Provider shall not have any interest that will conflict, as determined by CMS and the Department, with the performance MCO's services under the Three-Way Contract, including without limitation any financial, legal, contractual or other business interest in any entity performing enrollment functions for the Department. [Section 5.3.17 of Three-Way Contract]

124. If requested by the State of Illinois in response to a background check of any officer, employee, or agent of the Provider, the Provider shall immediately reassign any such individual who, in the opinion of the State of Illinois, does not pass the background check. [Section 5.3.21.1 of Three-Way Contract]

125. Provider is prohibited from giving gifts to Department employees, and from giving gifts to, or accepting gifts from, any person who has a contemporaneous contract with the Department involving duties or obligations related to the Three-Way Contract. [Section 5.3.21.8 of the Three-Way Contract]

126. As requested by MCO, Provider shall submit disclosures in accordance with 42 C.F.R. § 455 and 42 C.F.R. § 1002.3. [Section 5.1.6 of Three-Way Contract]

127. Provider shall notify MCO immediately if Provider has lost any required license or state or federal approval, or has been excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 *et seq.* [Sections 2.7.1.3 and 5.3.4 of Three-Way Contract]

128. Provider and its downstream and related entities shall allow MCO to access the medical records of Enrollees, and such access shall include the right to make and/or obtain a copy (in either electronic or hardcopy form) of such records. [Section 2.13.4.2.3 of Three-Way Contract]

129. If the Provider is discharging an Enrollee from a hospital, Provider must assure that the Enrollee receives a written notice in compliance with requirements set forth in 42 C.F.R. §§ 422.620–422.622. [Section 2.12.7.1 of Three-Way Contract]

130. Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees. [Section 2.8.6 of Three-Way Contract]

131. Provider must be appropriately and continually licensed or certified, as applicable, pursuant to federal and statement requirements. [Section 2.7.2.2.4 of Three-Way Contract]

132. Provider shall conduct all activities in accordance with the Enrollee rights and protections set forth under 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and Appendix B ("Enrollee Rights") of the Three-Way Contract. [Appendix B of Three-Way Contract]

133. Provider may not reuse or provide other entities access to the CMS or Illinois information systems, or data obtained from the CMS or Illinois information systems, to support any line of business other than the MMAI for which the MCO contracted with CMS and the State of Illinois. [Appendix F of Three-Way Contract]

134. Provider acknowledges and agrees that compliance with Sections 5.3.22 through 5.3.32 of the Three-Way Contract and each subsection thereof (collectively, the "Standard Certifications") is a material requirement and condition of this Agreement during the entire term thereof, including during any renewal periods. By executing the Agreement, Provider certifies compliance with the Standard Certifications in their entirety, and Provider is under a continuing obligation to remain in compliance with, and to report any non-compliance with respect to, the Standard Certifications. Furthermore, Provider shall include the Standard Certifications in any subcontracts or other contracts with downstream entities or related entities that Provider enters into with respect to the provision of Covered Services to Enrollees dually eligible for both Medicare and Medicaid under the Three-Way Contract and the MMAI, including the performance of any activities delegated to Provider in connection with the Three-Way Contract and the MMAI; if the Agreement extends over multiple fiscal years, including the initial term and all renewals, Provider and any such subcontractors, downstream entities, or related entities shall confirm compliance with the Standard Certifications in the manner and format determined by the State of Illinois by the date specified by the State of Illinois, and in no event later than July 1 of each year that the Agreement remains in effect.

If the Parties determine that any Standard Certification is not applicable to the Agreement, such Standard Certification may be stricken without affecting the remaining Standard Certifications.

As part of each Standard Certification, Provider acknowledges and agrees that if Provider or its subcontractors, downstream entities, or related entities provide false information, or fail to be or remain in compliance with the Standard Certifications, one or more of the following sanctions will apply: (a) the Agreement may be void by operation of law; (b) the State of Illinois may void the Agreement; and (c) the Provider and its subcontractors, downstream entities, or related entities may be subject to one or more of the following: suspension, debarment, denial of payment, civil fine, or criminal penalty. Identifying a sanction or failing to identify a sanction in relation to any of the Standard Certifications does not waive imposition of other sanctions or preclude application of sanctions not specifically identified.

a. Provider certifies it and its employees will comply with applicable provisions of the United States Civil Rights Act, Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act (42 U.S.C. § 12101, *et seq.*), and applicable rules in performance of this Agreement.

b. Provider certifies, if applicable, that it is a properly formed and existing legal entity (30 ILCS 500/1.15.80, 20-43); and as applicable has obtained an assumed name certificate from the appropriate authority, or has registered to conduct business in Illinois and is in good standing with the Illinois Secretary of State.

c. Provider certifies it has neither been convicted of bribing or attempting to bribe an officer or employee of the State of Illinois or any other state, nor made an admission of guilt of such conduct that is a matter of record. 30 ILCS 500/50-5.

d. If Provider employs twenty-five (25) or more employees and the Agreement is worth more than $5,000, Provider certifies that it will provide a drug free workplace pursuant to the Drug Free Workplace Act (30 ILCS 580).

e. Provider certifies that neither Provider nor any substantially owned affiliate of Provider is participating or shall participate in an international boycott in violation of the U.S. Export Administration Act of 1979 or the applicable regulations of the U.S. Department of Commerce. This applies to contracts that

exceed $10,000 (30 ILCS 582).

f. Provider certifies that it has not been convicted of the offense of bid rigging or bid rotating or any similar offense of any state or of the United States (720 ILCS 5/33E-3, E-4).

g. Provider certifies that it complies with the Illinois Department of Human Rights Act and rules applicable to public contracts, including equal employment opportunity, refraining from unlawful discrimination, and having written sexual harassment policies (775 ILCS 5/2-105).

h. Provider warrants and certifies that it and, to the best of its knowledge, its subcontractors, downstream entities, or related entities, have and will comply with Executive Order No. 1 (2007). That Order generally prohibits contractors and subcontractors from hiring the then-serving Illinois Governor's family members to lobby procurement activities of the State of Illinois, or any other unit of government in Illinois including local governments if that procurement may result in a contract valued at over $25,000. This prohibition also applies to hiring for that same purpose any former State of Illinois employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity.

i. Provider certifies that it is not currently barred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal or state department or agency, and is not currently barred or suspended from contracting with the State of Illinois under Section 50-35(f), 50-35(g) or 50-65 of the Illinois Procurement Code, 30 ILCS 500/1-1 *et seq.* If at any time during the term of this Agreement, Provider becomes barred, suspended, or excluded from participation in this transaction, Provider shall, within thirty (30) days after becoming barred, suspended, or excluded, provide to the Department a written description of each offense causing the exclusion, the date(s) of the offense, the action(s) causing the offense(s), any penalty assessed or sentence imposed, and the date any penalty was paid or sentence complete.

j. Provider certifies that, to the best of its knowledge and belief, no federally appropriated funds have been paid or will be paid by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, or the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Provider shall complete and submit Standard Form LLL, "Disclosure Forms to Report Lobbying," in accordance with its instructions. Such form is to be obtained at Provider's request from the Department's Bureau of Fiscal Operations. Provider shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this Agreement was executed. Submission of this certification is a prerequisite for making or entering into the transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

135. Provider acknowledges and agrees that MCO shall not pay for any item or service (other than an emergency item or service, not including items or services furnished in an emergency room or hospital): (a) furnished under the Three-Way Contract by any individual or entity during any period when that individual or entity is

excluded from participation under Titles V, XVIII, XIX, or XX or Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act; (b) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, XIX, or XX or Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); or (c) furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments. Provider furthermore acknowledges and agrees that MCO shall not pay for any item or service: (a) for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; or (b) furnished by a home health care services agency or organization, unless that agency or organization provides the State with a surety bond upon the implementation of Section 1861(o)(7) of the Social Security Act. [Section 2.7.1 of Three-Way Contract]

Individual Sites Regulatory Addendum – Signature Page

Individual Sites Regulatory Compliance Addendum - Exhibit B-11

Louisiana Medicaid/CHIP Compliance Addendum

Aetna Better Health of Louisiana ("Company" or "MCO") is under contract with the Louisiana Department of Health and Hospitals, ("Healthy Louisiana" f/k/a "Bayou Health" "State Agency" or "DHH") to provide Medicaid managed care services to Enrollees as part of the Healthy Louisiana program. This Addendum (the "Addendum") is incorporated by reference into the Agreement. The provisions of this Addendum are required by the State Contract for all of Company's downstream providers and subcontractors, including but not limited to suppliers and/or vendors of ABH.

For purposes of this Addendum, the term "Supplier" shall mean the individual or entity executing the Agreement, which may be a health care physician, provider, group, facility, hospital, individual or entity executing the Agreement, as identified on the first page of the Agreement. Capitalized terms used and not otherwise defined in this Addendum shall have the meanings set forth in the Agreement or, if not defined in the Agreement, as defined in the State Contract or under Louisiana law. Pertinent information regarding the Healthy Louisiana program, RFP and contracts with the MCOs can be found on the Medicaid page of the Department of Health and Hospitals website at: http://new.dhh.louisiana.gov

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, including but not limited to any Waiver Services and/or SPA, then the terms of the State Contract will govern and control. [RFP § 7.1.5].

If any requirement in the Agreement or this Addendum is determined by DHH to conflict with the contract between DHH and Company, such requirement shall be null and void and all other provisions shall remain in full force and effect.

To the extent applicable to the services provided by Supplier pursuant to the Agreement, the following provisions apply.

1. DEFINITIONS

When used in the Agreement, all capitalized terms shall have the following meanings:

Bayou Health (now known as Healthy Louisiana). The full risk-bearing MCO health care delivery system, authorized by La. R.S. 36:254 and operated by DHH under the authority of the Medicaid State Plan, as amended, responsible for

providing specified Medicaid core benefits and services included in the Medicaid State Plan and Waiver Services to Medicaid recipients. [RFP § 2.2.1].

Basic Behavioral Health Services ("Basic BHS"). Mental health and substance abuse services, which are provided to Members with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders that are provided in the Member's PCP office by the Member's PCP as part of primary care service activities. Basic BHS shall include, but not be limited to, screening, prevention, early intervention, medication management, treatment and referral services as defined in the Medicaid State Plan (or as otherwise authorized by the Healthy Louisiana program) Basic BHS are further defined as those provided in the Member's PCP or medical office by the Member's non-specialist physician (i.e., D.O., M.D., A.P.R.N.) as part of routine physician evaluation and management activities. All such services shall be Covered Services for Members with both physical and behavioral health coverage. [RFP §§ 6.4.1.1 & Definitions].

Care Management. Overall system of medical management encompassing Utilization Management, Referral, Case Management, Care Coordination, Continuity of Care and Transition Care, Chronic Care Management, Quality Care Management, and Independent Review.

Children's Health Insurance Program ("CHIP"). The program created in 1997 by Title XXI of the Social Security Act and known in Louisiana as CHIP. [RFP § Definitions].

Claim. In addition to the provisions of the Agreement, Claim means (1) a bill for services, (2) a line item of service or (3) all services for one recipient within a bill. [RFP § Definitions].

Clean Claim. A Clean Claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a Claim with errors originating in a State's claims system. It does not include a Claim from a provider who is under investigation for fraud or abuse, or a Claim under review for medical necessity. [RFP § Definitions].

Covered Services. Those health care benefits and services, including Waiver Services, to which an individual eligible for Medicaid/CHIP is entitled under the Medicaid State Plan. Covered Services shall be accessible to all Members in comparable timeliness, amount, duration and scope as those available to insured individuals in the same service area. [RFP § 7.1.2; Appendix O, #13].

Emergency Services. Covered inpatient and outpatient services, including Specialized BHS, that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. § 438.114(a) and Section 1932(b)(2) of the Social Security Act and that are needed to screen, evaluate and stabilize an emergency medical condition. Services defined as such under Section 1867(e) of the Social Security Act ("anti-dumping provisions"). If an emergency medical condition exists, the MCO is obligated to pay for the Emergency Service. Coverage of Emergency Services must not include any

prior authorization requirements, and the "prudent layperson" standard shall apply to both in-plan and out-of-plan coverage. [RFP § Definitions].

Enrollee. A Louisiana Medicaid or CHIP recipient who is currently enrolled in an MCO or other Medicaid Managed Care Program. [RFP § Definitions].

Louisiana Department of Health and Hospitals ("DHH"). 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 Louisiana.

Managed Care Organization ("MCO"). A private entity that contracts with DHH to provide core benefits and services to Enrollees in exchange for a monthly prepaid capitated amount per Member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to La. R.S. 22:1016, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid program be regulated by DHH.

Managed Care Program. The Louisiana Medicaid program providing statewide leadership to most effectively utilize resources to promote the health and well-being of Enrollees in DHH's Healthy Louisiana program. [RFP § Definitions].

Material Changes. Material Changes are changes affecting the delivery of care or services provided under the State Contract. Material Changes include, but are not limited to, changes in composition of the provider network, subcontractor network, the MCO's complaint and grievance procedures; health care delivery systems, services, changes to expanded services; benefits; enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that require DHH approval prior to implementation; and the MCO's capacity to meet minimum enrollment levels. DHH shall make the final determination as to whether a change is material. [RFP § Definitions].

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. [RFP § Definitions].

Medicaid State Plan. The binding written agreement between DHH and CMS, which describes how the Medicaid program is administered and determines the services for which DHH will receive federal financial participation.

Medical Record(s). A single complete record kept at the site of the Member's treatment(s), which documents medical or allied goods and services, including, but not limited to, outpatient and emergency medical health care services whether provided by the MCO, its subcontractor or any out-of-network providers. The records may be electronic, paper,

magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211; however, Supplier shall provide such Medical Record(s) upon request and without cost unless such production is deemed excessive or unreasonable by Company. [RFP § Definitions].

Medically Necessary Service(s) or Medical Necessity. Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) 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. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not Medically Necessary." Additionally, the Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by-case basis. [RFP § Definitions].

Member. As it relates to the Louisiana Medicaid/CHIP programs, the State Contract and the Agreement, Member refers to a Medicaid/CHIP eligible who enrolls in an MCO under the provisions of the State Contract and also refers to an "Enrollee" as defined in 42 C.F.R. § 438.10(a). [RFP § Definitions].

Policies. In addition to the policies and procedures promulgated by Company, that relate to the duties and obligations of the Parties under the terms of the Agreement, Policies include the general principles and practices by which DHH is guided in its management of the Title XIX program, as further set forth and defined by DHH promulgations and by state and federal rules and regulations. [RFP § Definitions].

Preventive Care. Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs. There are three (3) levels of Preventive Care: primary, such as immunizations, aimed at preventing disease; secondary, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred and requires a face-to-face visit within four (4) weeks of Member request.

Primary Care Provider ("PCP"). An individual physician, nurse practitioner or physician assistant who accepts responsibility for the management of a Member's health care. The Primary Care Provider is the patient's point of access for Preventive Care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care) or admit the patient to a hospital. [RFP § Definitions].

Provider Preventable Condition. Preventable healthcare-acquired or other provider- preventable conditions and events, also known as never events, identified by DHH for nonpayment, such as but not limited to, bed pressure ulcers or decubitus ulcers; or events such as surgical or invasive procedures performed on the wrong body part or wrong patient; wrong surgical procedure performed on a patient.

Specialized Behavioral Health Services ("Specialized BHS"). Specialized behavioral health services shall include, but are not limited to, services specifically defined in the Medicaid State Plan and provided by a psychiatrist, psychologist and/or mental health rehabilitation provider. Specialized BHS shall also include any other BHS subsequently amended into the State Contract, Medicaid State Plan or approved Waiver Services. Effective December 1, 2015, these services shall be Covered Services for all covered populations except for Specialized BHS covered by the Coordinated System of Care ("CSoC") for youth enrolled with the CSoC coordinator. [RFP § 6.4.1.1].

State Contract. The written agreement between Company and DHH, the Government Sponsor, a copy of which shall be furnished to Supplier upon request. 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. [RFP §2.3.2].

Waiver Services. Those Medicaid services covered under the Section 1915(c) Home and Community Based Services ("HCBS") programs which in Louisiana are New Opportunities Waiver ("NOW"), Children¹s Choice, Adult Day Health Care ("ADHC"), Elderly Disabled and Adult ("EDA"), Supports Waiver, Residential Options Waiver ("ROW"), other 1915(c) waiver or other waiver program service that may be implemented. Participants in waivers are excluded from enrolling in an MCO. [RFP § Definitions].

2. SUPPLIER SERVICES AND OBLIGATIONS

2.1 Licensing Requirements. Supplier must be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain, throughout the term of the Agreement, all necessary licenses, certifications, registrations, permits and accreditations as required to provide Covered Services or perform other activities delegated by Company or as required by the State Contract. If DHH or Company discovers that Supplier is not properly licensed by the appropriate authority, Supplier shall immediately discontinue providing services to Members. Upon proper licensing by the appropriate authority and approval by DHH, Company may reinstate Supplier to provide services to Members. [RFP § 7.15.3; Appendix O, #12].

2.2 Exclusion, Suspension and/or Debarment and Screening. The MCO, as well as its subcontractors and providers, whether contract or non- contract, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. Supplier agrees and understands that any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by Company or the State, dependent upon the entity that identifies the payment of unallowable funds to excluded individuals. Supplier acknowledges and understands that Company shall not execute contracts with any provider who has been excluded from participation in federal healthcare programs under § 1128, § 1128A (42 U.S.C. § 1320a-7) or § 1156 (42 U.S.C. § 1320 c-5) of the Social Security

Act or state-funded health care programs. Supplier further acknowledges that Company is prohibited from entering into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders. Supplier shall comply with all federal requirements on exclusion and debarment screening. If Supplier is a tax-reporting entity that bills or receives Louisiana Medicaid funds flowing from the State Contract, Supplier shall screen its owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). [RFP §§ 4.1.2, 7.6.2.1, 7.13.6, 15.1.11 & 25.14.1; 42 C.F.R. § 1002].

2.3 Requirements of Covered Services. Supplier must provide, or arrange for the provision of, Covered Services or coverage of core benefits and services in the amount, duration and scope of core benefits and services specified in the Medicaid State Plan, as well as all specific requirements of the State Contract and the court-ordered requirements applicable to the *Chisholm vs. Kliebert* class, under the Agreement to Members through the last day that this Agreement is in effect. Supplier acknowledges that all final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee. In the event that Supplier is unable or unwilling to provide services to Members, Supplier shall notify Company within one (1) business day. [RFP § 7.11.6.7; Appendix O, #12 & 15].

Additionally, Supplier agrees and understands that the services to be provided hereunder shall be performed entirely within the fifty (50) United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. Supplier agrees that he, she or it will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. [RFP § 25.27.1; Appendix O, #43].

2.4 Fraud and Abuse Policies. To the extent applicable, Supplier, on behalf of itself and any subcontractors, agrees to comply with applicable provisions of the State Contract, including all provisions of Section 15 of the State Contract, and Company's Fraud and Abuse Compliance Plan, including its methods to identify, investigate and refer suspected fraud cases, or other compliance program developed by Company to prevent, reduce, detect, correct and report known or suspected fraud, waste and abuse in the administration and delivery of health care services. Supplier shall abide by all requirements of the State Contract regarding right of review and recovery by Company and DHH for possible acts of fraud, waste and abuse for services under this Agreement, including those rules governing complex reviews and potential overpayments and/or underpayments.

Company has the exclusive right of review and recovery for three hundred sixty-five (365) days from the original date of service to initiate a complex review of the Claim to determine a potential underpayment or overpayment. A complex review requires Company's review of medical, financial or other records, including on-site reviews is necessary to determine the existence of an improper payment. Supplier understands that Company is prohibited from giving notice to Supplier in instances resulting from suspected fraud that Company has identified to DHH, MFCU or other appropriate law enforcement agency, unless approved by DHH.

Company and Supplier shall, upon request and as required by the State Contract or state and/or federal law, make available to the MFCU any and all administrative, financial and Medical Records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the

requesting agency. In addition, the MFCU shall, as required by the State Contract or state and/or federal law, be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor, supplier or provider during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU. [RFP §§ 15.1.16.2, 15.1.18-19 & 15.7.2].

2.5 Byrd Anti-Lobbying Amendment. Supplier further agrees to comply with the Byrd Anti-Lobbying Amendment, which provides that contractors who apply or submit bids shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. § 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier, up to the recipient (45 C.F.R. § 3). [RFP § 25.3.1.13].

2.6 Referrals. As applicable to services provided under the Agreement, Supplier shall adhere to Company's referral system and guidelines to ensure that services are furnished to Enrollees promptly and without compromise to care. Supplier agrees to accurately document and cooperate with Company regarding requested referral reporting and monitoring activities, documentation of specialty health care and out-of-network referrals, services and follow-up activities and ensure that all are included in the Medical Record maintained by the Member's PCP. Supplier also agrees to adhere to Company's procedures and criteria for making referrals and coordinating care in accordance with the court-ordered *Chisholm vs. Kliebert* requirements and with behavioral health providers and agencies that will promote continuity, as well as, cost-effective care. [RFP §§ 6.1.12 & 6.28.1].

2.7 Responsibilities of Primary Care Providers. If Supplier is a PCP, the PCP shall serve as the Member's initial and most important point of interaction. The PCP shall also be responsible for the following:

(a) Managing and coordinating the medical and behavioral health care needs of Members to assure that all Medically Necessary services are made available in a timely manner [RFP § 7.8.2.1];

(b) Referring patients to subspecialist and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available [RFP § 7.8.2.2];

(c) Communicating with all other levels of medical care to coordinate and follow-up the care of individual patients, including real time consultations with behavioral health providers for behavioral health issues and medication consultations [RFP §§ 2.3.10.5 & 7.8.2.3];

(d) Providing the coordination necessary for the referral of patients to behavioral health providers and specialists and for the referral of patients for Basic BHS, Specialized BHS and/or services that may be available through Medicaid fee-for-service ("FFS") [RFP §§ 6.29.2.2 & 7.8.2.4];

(e) Maintaining a Medical Record of all services rendered by the PCP and record of referrals to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care [RFP § 7.8.2.5];

(f) Development of a plan of care to address risks and medical needs and other responsibilities regarding Care Management as set forth in Company Policies and the State Contract and as required by 42 C.F.R. § 438.208 [RFP §§ 6.29.1 & 7.8.2.6];

(g) Ensuring that in the process of coordinating care, each Enrollee's privacy is protected consistent with the confidentiality requirements of state law and 45 C.F.R. Parts 160 and 164, which set forth the requirements regarding the privacy of individually identifiable health information [RFP § 7.8.2.7];

(h) Providing after-hours availability to patients who need medical advice. At a minimum, PCP offices must have a return call system staffed and monitored in order to assure that the Member is connected to a designated medical practitioner within thirty (30) minutes of the call [RFP § 7.8.2.8];

(i) Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital[RFP § 7.8.2.9];

(j) Provide Basic BHS and refer Members to the appropriate health care specialist as deemed necessary for Specialized BHS. [RFP §7.8.2.1];

(k) Participate in training provided by Company regarding the appropriate utilization of basic behavioral health screenings in the primary care setting [RFP § 6.35.8];

(l) Cooperate with Company to increase screening for developmental, behavioral and social delays, as well as screening for child maltreatment risk factors, trauma and adverse childhood experiences. [RFP § 6.4.9.1];

(m) Working with Company case managers to develop plans of care for Members receiving Case Management services [RFP § 7.8.2.10];

(n) Participating with Company's Case Management team, as applicable and Medically Necessary [RFP § 7.8.2.11]; and

(o) Conducting screens for common behavioral issues, including, but not limited to, depression, anxiety, trauma/adverse childhood experiences and substance use, to determine whether the Member needs BHS. [RFP §§ 6.4.5.6.4.9 & 7.8.2.12].

2.8 Medically Necessary/Preventive Services. Supplier may not refuse to provide Medically Necessary or preventive Covered Services to Members covered under the Agreement or the State Contract for non-medical reasons (except those services allowable under federal law for religious or moral objections). However, Supplier is not required to accept or continue treatment of a patient with whom Supplier feels he/she cannot establish and/or maintain a professional relationship.

2.9 Emergency Services. Supplier shall render Emergency Services, including Specialized BHS, without the requirement of prior authorization of any kind. Supplier agrees to cooperate with Company's obligations to monitor utilization of Emergency Services and correct inappropriate emergency department utilization. [RFP § 6.8.1.1; Appendix O, #14].

2.10 Laboratory Services. If Supplier performs laboratory services, Supplier must meet all applicable federal and state law requirements, including CLIA requirements and the provisions of 42 C.F.R. § 493.1 and § 493.3. [RFP § 7.8.12.1; Appendix O, #15].

2.11 Behavioral Health Services. DHH and Company support the integration of physical services and BHS through screening and strengthening prevention/early intervention at the primary care level of care. As applicable, Supplier shall utilize behavioral health screening tools and protocols consistent with industry standards. [RFP § 6.4.9].

PCP and Company shall cooperate and collaborate with behavioral health specialists and other service providers who serve Medicaid Members to ensure the coordination and provision of services to Members as specified in the Medicaid State Plan. In addition, Supplier is not permitted to encourage or suggest, in any way, that Members be placed in state custody to receive medical or specialized BHS covered by DHH. [RFP §§ 6.27.2.1,6.29.2.2 & 7.12].

2.12 Treatment Decisions. As applicable to services provided under the Agreement, Supplier shall be familiar with the package of benefits offered by DHH set forth in the State Contract and DHH's requirement that providers make treatment decisions based upon individual medical needs. Supplier must comply with DHH's requirements governing Member rights and responsibilities as set forth in State Contract, Company Policies and applicable state and federal law. [RFP § 12.17.15.1].

2.13 Access Standards and Appointment System. As applicable to services provided under the Agreement, Supplier shall abide by the appointment availability and access standards for core benefits and/or expanded services, when applicable, to ensure that Members' needs are sufficiently met. Supplier shall ensure that appointments are on a timely basis, as follows: [RFP §§ 7.1.3, 7.2.1 & 7.5.1.1; Appendix SS].

(a) Routine, non-urgent or Preventive Care visits scheduled within six (6) weeks. For BHS, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral [RFP § 7.2.1.4];

(b) Urgent care visits within twenty-four (24) hours. Supplier must provide or make arrangements, as directed by Company or through other arrangements, for a patient to obtain urgent care, including behavioral health care, twenty-four (24) hours per day, seven (7) days per week. Urgent care may be provided directly by the PCP or directed by Company through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request [RFP § 7.2.1.2];

(c) Emergent or emergency visits immediately upon presentation at a service delivery site. Emergency Services must be available at all times. Emergent, crisis or emergency BHS must be available at all times, and an appointment shall be arranged within one (1) hour of request [RFP § 7.2.1.1];

(d) Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition [RFP § 7.2.1.3];

(e) In office waiting times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time in the waiting room and examining room. If Supplier is delayed, patients shall

be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment [RFP § 7.2.1.9-10];

(f) Maternity Care:

(i) Initial appointments for prenatal visits for newly enrolled pregnant women, who must be treated without unreasonable delay, shall meet the following timetables from the postmark date the MCO mails the Member's welcome packet:

(1) In the first trimester within fourteen (14) days;

(2) In the second trimester within seven (7) days;

(3) In the third trimester within three (3) day;

(ii) Initial appointments for high risk pregnancies within three (3) days of identification of high risk by Company or maternity care provider, or immediately if an emergency exists [RFP § 7.2.1.7];

(g) Specialty care consultation within one (1) month of referral or as clinically indicated [RFP § 7.2.1.5];

(h) Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated [RFP § 7.2.1.6];

(i) Follow-up to emergency department visits in accordance with emergency department attending provider discharge instructions [RFP § 7.2.1.8];

(j) Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures [RFP § 7.2.1.11]; and

(k) Direct contact with a qualified clinical staff person must be available through a toll-free number at all times. [RFP § 7.2.1.12].

2.14 Insurance. As required by the laws applicable to Supplier, Supplier shall secure and maintain throughout the term of the Agreement, all necessary, and in the amounts required by the State Contract and/or Company, liability, workers' compensation and malpractice insurance or other coverage as is necessary to adequately protect Members and Company under the Agreement. Supplier shall furnish Company with written verification of the existence of such coverage at all times during the Agreement. Supplier shall not commence performance under the Agreement until all insurance requirements have been obtained and approved by Company. To the extent FQHCs are exempt from maintaining any type of insurance, Company shall waive this requirement. [RFP § 2.5.2.2; Appendix O, #33].

2.15 No Interference by Company. Subject to the limitations set forth in 42 C.F.R. § 438.102(a)(2), Company agrees that it shall not prohibit or otherwise restrict Supplier, acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, regardless of whether benefits for such care or treatment are provided under the State Contract, for the following:

(a) The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the Enrollee needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; and

(d) The Enrollee'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.

[RFP § 7.16.1].

2.16 Required Disclosures. Supplier shall comply with the disclosure provisions of 42 C.F.R. § 455, Subpart B and disclose all required information regarding significant business transactions, ownership and control information to Company, including disclosure of business transactions with wholly-owned suppliers or subcontractors, as well as otherwise required by applicable law. Supplier agrees to submit the required disclosures of ownership to Company at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to disclosure information, at least annually or upon request. Supplier shall also comply with any and all disclosures required to ensure mental health parity, including, but not limited to requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("MHPAEA"), the State Contract and DHH. [RFP §§ 7.15.2.8.3.35 & 15.1.10; Appendix O, #19; 42 C.F.R. §§ 455.104-.105].

2.17 Training. Supplier shall participate in applicable training sessions provided by Company and/or DHH to ensure that Supplier, and any subcontractors, adhere to Company policies and procedures and Medicaid regulations to fulfill its requirements, including, but not limited to, but not limited to, training on integrated care, Permanent Supportive Housing ("PSH"), appropriate utilization of basic physical health screenings in the behavioral health setting and marketing guidelines, restrictions and limitations. [RFP §§ 2.3.10.3 (integrated care), 4.6.1, 4.6.7.4 (PSH), 6.4.5.6.4.9, 6.4.11.4, 6.35.8. 6.35.9.1.6, 3.35.9.1.12, 7.6.6, 7.9.5.7, 7.15.2.8.3.33, 10.5.1 & 10.5.4.2-.4].

2.18 Covered Population. Supplier shall provide services to the enrollment populations identified in and in accordance with the State Contract, as amended from time to time. [Appendix O, #10].

2.19 Self-Assessment. If applicable, Supplier shall complete, at least annually unless otherwise requested by Company or DHH, a self-assessment using the Integrated Practice Assessment Tool or other assessment method provided by Company. In addition, Supplier shall cooperate with Company in providing data necessary for Company to meet its reporting obligations to DHH on behavioral health integration. [RFP § 2.3.10.1-.2].

2.20 Prescription Data Inquiry Requirements. Provider shall utilize the electronic Medicaid Clinical Data Inquiry system ("e-CDI"), accessible via www.lamedicaid.com, to perform medication searches within a Member's medical history to ensure that appropriate medication management is conducted. [RFP § 7.15.2.8.3.11].

2.21 Audit Requirements. If Supplier performs a key internal control, Supplier shall submit to an independent SSAE 16 SOC type I and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by DHH, Supplier must provide a quality control plan, such as third party Quality Assurance ("QA"), Independent Verification and Validation ("IV&V"), and other internal project/program reviews and audits. [RFP § 21.9; Appendix O, #30].

2.22 Health Information Technology ("HIT"). Supplier agrees and understands that Company encourages and DHH may later require Supplier to adopt HIT and its meaningful use, with specific emphasis on connection to the Louisiana Health Information Exchange ("LaHIE") and development of a secure, web-accessible health record for Members, such as a personal health record ("PHR"). [RFP § 16.3.4].

2.23 Emergency Departments. All emergency departments ("EDs") shall exchange admit discharge transfer ("ADT") data with LaHIE's ED visit registry to aid in identification and creation of Policies around high utilizers, drug-seeking behavior and chronic disease management. The visit registry consists of three basic attributes: (i) the ability to capture and match patients based on demographics information, (ii) the ability to identify the facility at which care is being sought and (iii) at minimum, the chief complaint of the visit. These three (3) pieces of information are commonly available through the HL7 ADT message standard and in use by most ED admission systems in use today across the country. [RFP § 16.3.5].

2.24 Hospitals. Hospitals shall comply with the data submission requirements of state law. Including, but not limited to, syndromic surveillance data under the Sanitary Code of the State of Louisiana (LAC 51:II.105). All Suppliers are encouraged to use LaHIE where direct connections to public health reporting information systems are not feasible or are cost prohibitive. [RFP § 16.3.6].

2.25 Immunizations. Provider shall use vaccines available without charge under the Vaccine for Children ("VFC") Program for Medicaid children eighteen (18) years old and younger. Immunizations shall be given in conjunction with EPSDT/Well Child visits or when other appropriate opportunities exist. Supplier shall report the required immunization data into the Louisiana Immunization Network for Kids "(LINKS") administered by the DHH/Office of Public Health. [RFP §§ 6.7.2 & 6.7.4].

2.26 Coordination with Other Service Providers. Supplier shall make best efforts to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs, Healthy Start programs, Aging and Disability Councils, Areas on Aging, Nurse Family Partnership, Early Intervention programs and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the Enrollee). [RFP § 7.12].

2.27 Prescription Monitoring Program ("PMP"). Upon writing the first prescription for a controlled substance and then annually thereafter, Supplier, which is a licensed prescriber, shall utilize and conduct Member-specific inquiries in the PMP for Members with behavioral health diagnosis and/or substance use disorders. The physician shall print the PMP query and file it as part of the recipient's record. Company shall conduct sample audits to verify compliance. Prescribers are encouraged to conduct additional PMP queries depending on the Member's specific medical history and diagnosis. [RFP § 6.3.6.6].

2.28 Incident Reporting. Supplier agrees to comply with Company's incident reporting procedures, including utilizing Company's or DHH's incident reporting management system, and timely report quality of care concerns and adverse incidents to Company. [RFP § 14.8].

3. CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Compensation. Supplier shall promptly submit accurate information needed to make payment under the terms of the Agreement, identifying the name and address of the official payee to whom payment shall be made and the method and amount of compensation. Supplier shall make full disclosure of the method and amount of compensation or other consideration received from Company. In accordance with 42 C.F.R. § 438.12(e), Supplier is not compensated to provide incentives for Company to deny, limit, or discontinue Medically Necessary Services to any Member. [RFP § 7.15.2.8.3.28; Appendix O # 26].

3.2 Payment of Claims. Supplier agrees to comply with DHH's Claims processing guidelines and timely filing guidelines as set forth in the State Contract and shall (i) submit Claims associated with Covered Services for Members directly to Company or Company's subcontractor and (ii) unless unreasonable under the Agreement, agree to submit to and receive from Company, Claims information through electronic data interchange. Company agrees to pay 90% of all Clean Claims submitted by Supplier within fifteen (15) business days of the date of receipt and 99% of all Clean Claims submitted by Supplier within thirty (30) business days of the date of receipt. The date of receipt is the date that Company receives the Claim, as indicated by the date stamp on the Claim. The date of payment is the date of the check or other form of payment. Company and Supplier may, by mutual agreement, establish an alternative payment schedule herein. Supplier must submit all Medicaid only Claims for Covered Services for payment no later than three hundred sixty-five (365) days from the date of service. Supplier shall submit Claims involving third-party liability within the lesser of (i) one hundred eighty (180) days of resolution by the third party or (ii) three hundred sixty-five (365) days from the date of service.

Supplier must identify potential Medicare or third-party liability coverage to Company before submitting Claims or encounters to Company. Pursuant to federal and state law, the Medicaid program by law is intended to be the payor of last resort; thus, all other available third-party liability resources must meet their legal obligation to pay Claims before Company pays for the care of a Medicaid Member. Provider shall make best efforts to ensure it receives compensation first from all other available resources before accepting compensation from Company. [RFP §§ 5.13.1.1, 7.15.2.8.3.9, 17.2.8, 17.3.2, 17.3.5 & 17.8.8; Appendix O, # 27-28].

3.3 Capitation Arrangement Payments. With respect to payments made through a capitation arrangement, Supplier shall submit all encounter data to the same standards of completeness and accuracy as required for receiving and settling of FFS Claims. If Supplier becomes aware for any reason that he or she is not entitled to a PMPM payment for a particular Member (i.e., patient dies), Supplier shall immediately notify both Company and DHH by certified mail, return receipt requested. Supplier acknowledges and understands that such capitation arrangements may be subject to adjustment. [RFP § 17.8.3].

3.4 Timely Reimbursement. In the event that DHH deems Company unable to timely process and reimburse Claims, and requires Company to submit Claims for reimbursement to an alternate Claims processor, if applicable, to ensure timely reimbursement, Supplier agrees to accept reimbursement at no more than the Company's contracted reimbursement rate or DHH's established FFS rate. [RFP § 9.1].

3.5 In-Network Reimbursement. Unless mutually agreed upon by the Parties, Suppliers who are in-network providers shall not be reimbursed by Company for defined core benefits and services at less than the Medicaid FFS rate in effect on the date of service or its equivalent (such as a DRG case rate). Supplier agrees and understands that DHH is responsible for setting and defining minimum rates for Covered Services. [RFP § 9.1].

3.6 Member Billing. Supplier shall accept payment for Covered Services made by Company under the terms of this Agreement as payment-in-full and shall not solicit or accept any surety or guarantee of payment from DHH or any Member, which shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally responsible person of the Member being served. In accordance with federal law and regulations, Supplier shall not bill Members any amount greater than would be owed if Company provided the services directly. Members shall not be held liable for the costs of any and all services not covered by Company or in cases where Supplier failed to obtain required authorization. [RFP §§ 5.12, 6.31.4 & 25.26; Appendix O, # 31].

Supplier may impose cost sharing on Members in accordance with 42 C.F.R. § 447.50-.57; provided, however, it does not exceed the cost sharing amounts set forth in the Medicaid State Plan. To the extent cost sharing is required of a Member, Supplier shall not deny services because of the Member's inability to pay. Supplier agrees and understands that DHH reserved the right to amend cost sharing requirements. [RFP §§ 5.12.2-.3].

3.7 Encounter Claim Errors. If Supplier discovers an error or conflict with a previously adjudicated Claim, Supplier shall immediately notify Company and Company shall be required to adjust or void the encounter Claim within fourteen (14) days of notification by DHH, or, if circumstances exist that prevent Supplier from meeting this time frame, a specified date shall be approved by DHH. [Appendix O, #29].

3.8 FQHC/RHC ("Rural Health Center") Reimbursement. Company shall reimburse a contracted FQHC/RHC at an amount equal to the Prospective Payment System ("PPS") rate in effect on the date of service of each encounter. As applicable, Supplier agrees and understands that Company shall not enter into alternative reimbursement arrangements with FQHCs or RHCs. [RFP §§ 9.2.1-.2].

3.9 Compensation for UM Activities. In accordance with federal law and regulations, any compensation to Company, entities or individuals that conduct utilization management activities is not structured so as to provide incentives for the entity, individual or Company to deny, limit or discontinue Medically Necessary Services to any Member. [RFP § 8.21; 42 C.F.R. § 438.12(e)].

3.10 Reimbursement for Court-Ordered Services. All court-order behavioral health services are subject to medical necessity review. To be eligible for payment, the service must be Medically Necessary and a Covered Service, as determined by Company within DHH's medical necessity definition. [RFP § 8.15.1].

3.11 Payments to Excluded Suppliers. Supplier agrees and understands that federal financial participation is not available for services, except for Emergency Services, delivered by providers excluded from Medicare, Medicaid or CHIP. If Supplier has been excluded, Supplier shall return all amounts paid by Company for services rendered as an excluded provider. Supplier agrees and understands that any outstanding payments due to an excluded supplier or provider for dates of service before the effective date of exclusion shall be suspended, and release of such funds is contingent upon DHH approval. [RFP § 15.4].

3.12 Offset. Supplier agrees and understands that DHH or Company on behalf of DHH may recover any overpayments from Supplier identified through an automated or similar review, and such funds shall be returned to DHH. Supplier further agrees that Company shall not offset any payments made to a behavioral health provider for BHS and recouped by DHH when, and only when, DHH has verified that Company was at fault for the error in payment. [RFP §§ 7.15.2.8.3.20 & 15.7.7].

3.13 Provider Preventable Conditions. Company shall not reimburse and shall not be obligated to reimburse Supplier for Provider Preventable Conditions as defined herein. [RFP § 7.13.3.7].

3.14 Location of Services. Supplier r understands and agrees that it will not request or accept reimbursement or payment for items or services provided under the Agreement by any individual or entity located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. [RFP § 5.3.2].

4. COMPLIANCE WITH POLICIES

4.1 Compliance with Applicable Law. Supplier agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services under the Healthy Louisiana program, including Title VI and VII of the Civil Rights Act of 1964, the Vietnam Era Veterans' Readjustment Assistance Act of 1974, Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, Section 202 of Executive Order 11246 and all applicable

requirements imposed by or pursuant to the regulations of HHS and as named in the State Contract. Provider shall provide physical access for Medicaid Members with disabilities. [RFP §§ 7.6.3.2 & 25.3; Appendix O, # 34].

4.2 Reporting Communicable Diseases. Supplier shall comply with the La. Admin. Code; Sanitary Code, Title 51, Part II, Chapter 1 and La. R.S. 40:4 *et seq.* by reporting all cases of communicable diseases such as tuberculosis, sexually transmitted diseases and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome infection to the state public health agency within twenty-four (24) hours of notification from the date of service.

4.3 Program Compliance. To the extent applicable to Supplier, Supplier shall adhere to and measure compliance with the Quality Assessment and Performance Improvement Program ("QAPI"), Utilization Management ("UM") requirements and Provider Incentive Programs ("PIP") specified by DHH and/or Company, including, as applicable based on type of Supplier, those set forth in the State Contract, PIPs or corrective action plans. Such programs and requirements shall be incorporated into the Agreement. [RFP §§ 7.15.2.8.3.12, 7.15.2.8.3.21, 8.1.19 & 8.1.21; Appendix O, # 38].

4.4 Grievance System. Company will provide Supplier with information regarding Company's grievance system that complies with state and federal laws, including 42 C.F.R. § 438, Subpart F. Supplier agrees to adhere to the requirements of Company's grievance and appeals procedures and adverse incident reporting requirements. Supplier shall comply with Company's Policies for grievance and appeal procedures as well as facilitate Member grievance and appeals, assist Members as required and timely implement Company and DHH decisions and recommendations related to grievances, appeals, Claim disputes and adverse incidents. No punitive action will be taken against any provider who files on behalf of a Member. [RFP §§ 7.15.2.8.3.23, 7.15.2.8.3.26-.27 & 13; Appendix O, #20; 42 C.F.R. § 438.10(g)(1)].

4.5 Record Keeping System. Supplier shall maintain an adequate record system for recording clinical services with appropriate billing, service providers, charges, dates and all other commonly accepted information elements for Covered Services rendered to Members under the terms of the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed). Company, Members and their representatives shall be given access to and can request copies of Members' Medical Records to the extent and in the manner provided by La. R.S. 40:1299.96 and 45 C.F.R. § 164.524 and as subject to reasonable charges. [RFP § 7.15.2.8.3.10; Appendix O, #16].

4.6 Maintenance of Medical Records. Supplier shall maintain a unified Medical Record for each Member following Company's documentation guidelines regarding Medical Records, and the medical record documentation guidelines set forth in the State Contract. The Medical Record must be (i) accurate and legible; (ii) safeguarded against loss, destruction or unauthorized use, be maintained in an organized fashion, for all Members evaluated or treated, and be accessible for review and audit; and (iii) readily available for review and provide medical and other clinical data required for QAPI and UM review. [RFP §§ 15.6.1-.2].

At a minimum, the Medical Record must include the following:

(a) Member identifying information, including name, identification number, date of birth, sex and legal guardianship, if applicable;
(b) Primary language spoken by the Member and any translation needs of the Member;
(c) Services provided through Company, date of service, service site and name of service provider;
(d) Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first Member visit with or by Company;
(e) Referrals including follow-up and outcome of referrals;
(f) Documentation of emergency and/or after-hours encounters and follow-up;
(g) Signed and dated consent forms, as applicable;
(h) Documentation of immunization status;
(i) Documentation of advance directives, as appropriate;
(j) Documentation of each visit must include:

(i) Date and begin and end times of service;
(ii) Chief complaint or purpose of the visit;
(iii) Diagnoses or medical impression;
(iv) Objective findings;
(v) Patient assessment findings;
(vi) Studies ordered and results of those studies (*e.g.* laboratory, x-ray, EKG);
(vii) Medications prescribed;
(viii) Health education provided;
(ix) Name and credentials of the provider rendering services (*e.g.* MD, DO, OD) and the signature or initials of the provider; and
(x) Initials of providers must be identified with correlating signatures.

(k) Documentation of EPSDT requirements including but not limited to:

(i) Comprehensive health history;
(ii) Developmental history;
(iii) Unclothed physical exam;
(iv) Vision, hearing and dental screening;
(v) Appropriate immunizations; and
(vi) Appropriate lab testing including mandatory lead screening; and health education and anticipatory guidance.
(vii) Health education & anticipatory guidance.

4.7 Record Retention Policy. All records originated or prepared in connection with Supplier's performance of its obligations under the Agreement, including but not limited to, working papers related to the preparation of fiscal reports, Medical Records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by Supplier in accordance with the terms and conditions of the State Contract and the Agreement. Supplier agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under the Agreement, and as further required by DHH, for a period of six (6) years after the last payment was made for services provided to a Member and retained further if the records are under review, audit, or related to any matter in litigation until the review, audit, or litigation is complete. If any litigation, claim or other actions involving the records have been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of

the six (6) year period, whichever is later. Unless required production of records is deemed excessive or unreasonable by Company or if Supplier stores records on microfilm or microfiche, Supplier shall produce, at its expense, legible hard copy records upon the request of state or federal authorities, within twenty one (21) calendar days of the request. [RFP §§ 15.6.4 & 25.43; Appendix O, # 17].

4.8 Medicaid Records Retention. Except for Medical Records pertaining to once-in-a-lifetime events, Supplier shall retain any and all Member records (financial, medical, etc.) for a period of six (6) years after the last payment was made for Covered Services provided to a Member (or any greater period of time required by applicable federal and state law) or longer if the records are under review, audit, or related to any matter in any administrative or judicial action brought by or on behalf of the federal or state government until the review, audit or litigation is complete. This requirement pertains to the retention of records for Medicaid purposes only. Other state or federal laws may require longer retention periods. Per La. R.S. 40:1299.96, providers must retain their records for at least six (6) years. These minimum record keeping periods run from the last date of treatment. After these minimum record-keeping periods, destruction of records is permitted. Supplier shall ensure that any and all Member records are made available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of DHH or its authorized representative. [La. R.S. 40:1299.96; RFP § 15.6.4; Appendix O, # 17].

4.9 Access to Information and Records. Supplier acknowledges and understands that state authorities, such as DHH, the State Auditor's Office and the Louisiana Attorney General's Office, shall have the right to evaluate, through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract and the Agreement, including documents related to mental health parity, the quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Claims submitted to Company. Such evaluation, when performed, shall be performed with the cooperation of Supplier. Upon request, Supplier shall assist in such review. [RFP §§ 7.15.2.8.3.24 & 25.48; Appendix O, # 18].

4.10 Program Procedures. Supplier agrees to participate and cooperate in any internal and external quality assessment review, utilization management and grievance procedures and abide by all marketing and Member education guidelines established by Company, DHH and/or its designee, whether announced or unannounced. Supplier further agrees to comply with all limitations on Supplier marketing and any corrective action plan initiated by Company and/or required by DHH. Supplier shall monitor and report the quality of services provided under the Agreement and, if necessary, initiate a plan of correction or comply with a DHH or Company initiated corrective action plan to improve the quality of care in accordance with that level of care which is recognized as acceptable professional practice in Supplier's community and/or the standards established by Company, DHH and/or its designee. [RFP § 12.1.6; Appendix O, # 20-22].

4.11 Reports to Company. Supplier shall provide and cooperate with Company to provide all reports and clinical information, data and information relative to the provision of Specialized BHS necessary for reporting requirements and deliverables established by the State Contract, Behavioral Health Companion Guide, DHH, federal and state laws and any require follow-up to such other deliverables, including, but not limited to, providing additional information, on-site monitoring by Company or DHH, tracking of issues, service quality monitoring, performance accountability, access to services, housing and employment rates. [RFP §§ 7.15.2.8.3.18-.19, 7.15.2.8.3.30 & 18, *et al*; Appendix O, # 24].

4.12 Member Rights and Responsibilities. Supplier shall comply with all applicable state and federal laws pertaining to Member rights and privacy and shall consider and respect those rights when providing services to Members. Additionally, Supplier shall safeguard Member information in accordance with applicable state and federal laws and regulations and the policies and safeguards established by Company. [RFP § 12.17.15.1; Appendix O, # 25].

4.13 Notice of Legal or Administrative Actions. Supplier shall provide Company with immediate notification in writing by certified mail of any litigation, investigation, administrative legal action, complaint, claim or transaction that may reasonably be considered to have a material impact on Supplier's ability to provide services under the Agreement. Supplier shall also provide prompt notice of any claim made against Supplier by a third party, including a Member, that may result in litigation related in any way to Company's State Contract with DHH. [Appendix O, #39].

4.14 Reporting of Births. To the extent applicable, Supplier must report the births of newborns within twenty-four (24) hours of birth for enrolled Members using DHH's web-based Facility Notification System. If Supplier is a hospital, Supplier shall accurately register all births through the Louisiana Electronic Event System ("LEERS") administered by DHH/Vital Records Registry. [RFP §§ 11.10.4.2-.3].

4.15 Records Upon Termination. Company and Supplier recognize and agree that in the event of termination of the State Contract between Company and DHH, Supplier shall immediately make available to Company or its designated representative and to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to Company's and Supplier's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to DHH. [RFP § 24.3; Appendix O, # 7].

4.16 Failure to Comply with Contractual or Credentialing Requirements. In the event Supplier fails to comply with specific contractual and/or credentialing requirements as set forth in the Agreement or Company Policies, Supplier may be subject to monetary penalties, sanctions or reductions in payment, which shall include, but may not be limited to Supplier's failure or refusal to respond to Company's request for information, the request to provide medical records, credentialing information, etc. Penalties shall be imposed at the Company's discretion or by a directive of DHH that Company impose, at a minimum, financial consequences against Supplier as appropriate. [Appendix O, # 23].

4.17 Assistance to Members. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d, *et seq.*) and 45 C.F.R. Part 80, Supplier must take adequate steps, including coordination with Company, to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement. Suppliers shall deliver services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for cultural competency and linguistic needs, including the Member's prevalent language(s) and sign language interpreters in accordance with 42 C.F.R. § 438.206(c)(2). Company shall ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by:

(a) Collecting Member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider or supplier will be able to respond appropriately to the cultural needs of the community being served (note: Members must be given the opportunity to voluntarily disclose this information, it cannot be required);

(b) Assessing the cultural competency of Supplier on an ongoing basis, at least annually;

(c) Assessing Member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the Member including, but not limited to, race/ethnicity, age, gender, parish, etc.;

(d) Assessing supplier satisfaction of the services provided by Company at least annually; and

(e) Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to Company staff, behavioral health network providers and applicable suppliers for a minimum of three (3) hours per year and as directed by the needs assessments.

[RFP §§ 7.1.6 & 7.15.2.8.3.33-.34; Appendix O, # 40].

4.18 Covered Population. Supplier shall provide Covered Services to Members as required by the Healthy Louisiana program. If Supplier is a PCP, PCP confirms that his/ her total number of Medicaid Members shall not exceed 2,500 Medicaid/CHIP lives. Non-compliance with this provision may result in sanctions, including, but not limited to, financial sanctions, transfer of Members to another PCP within the Company or termination of the Agreement.

If Supplier provides BHS, Supplier shall provide Covered Services and BHS to at the minimum number of Members as required under the State Contract. The services and benefits provided under the Agreement shall be in accordance with the Covered Services of the Healthy Louisiana program and appropriate levels of care as defined by DHH and are incorporated herein by reference. [RFP § 7.15.2.8.3.32; Appendix O, # 10].

4.19 Coding Requirements. Supplier shall follow Company's requirements and guidelines for Claims coding and processing that are specific to each provider type. Company shall notify Supplier ninety (90) days before implementing changes to Claims coding and processing guidelines applicable to Supplier. The State and HHS may inspect and audit any financial records of Company, Supplier or its subcontractors. There shall be no restrictions on the right of the state or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. [RFP § 9.5.6].

4.20 Encounter Data. If Company has entered into any alternative reimbursement arrangement with Supplier under the terms of this Agreement, Supplier shall submit to Company all encounter data in a manner consistent with the same standards of completeness and accuracy as required for proper adjudication of FFS Claims by Company. [RFP §17.8 & Appendix O, #56]

4.21 Mental Health Parity. To ensure compliance with mental health parity requirements, Supplier agrees to comply with Company's and DHH's mental health parity Policies, procedures and practices and federal and state laws, including collecting and reporting data elements and taking any such action necessary for Company to comply with mental health parity requirements under the State Contract. Supplier agrees to comply with mental health parity regulations and any enforcement action, including, but not limited to, termination and restitution. Supplier shall complete mental health parity disclosure on provider enrollment forms as mandated by DHH. [RFP § 2.3.9.3].

4.22 HIPAA Policies. Supplier agrees and understands that Company's HIPAA and Medical Record Policies may change from time to time to comply with applicable state or federal law requirements, including requirements set forth by state or federal government agencies. As such, Supplier agrees that any required administrative or governmental changes shall be incorporated into the Agreement without formal amendment hereto, and Supplier shall execute any and all required HIPAA agreements, including business associate agreements. Moreover, Supplier shall request and obtain if possible a standardized release of information from each Member to allow Supplier to coordinate treatment with the Member's PCP. Supplier agrees to adhere to HIPAA and all applicable HIPAA regulations issued by the federal Department of Health and Human Services, including, but not limited to, the requirements and obligations imposed by those regulations regarding the conduct of electronic health care transactions and the protection and security of individual health information and any additional regulatory requirements imposed under HIPAA. Supplier understands and acknowledges that the State contract provides it with access to electronic databases, including but not limited to the Electronic Medicaid Eligibility Verification System ("eMEVS"), the e-CDI, and the Electronic Claims Status Inquiry ("e-CSI"), which Supplier acknowledges can provide, in some cases, access to information on individuals with whom Supplier has no treatment or other relationship, and Supplier shall abide by all requirements under HIPAA and ensure that the confidentiality of said information is fully maintained. [RFP §§ 7.15.2.8.3.14, 12.10.4 & 25.7.3].

4.23. Supplier Marketing Guidelines. To the extent applicable, Supplier agrees to adhere to the following marketing communication requirements:

(a) Supplier acknowledges and agrees that all marketing and Member education guidelines outlined in the State Contract are applicable to Company, its agents, subcontractors, volunteers, and/or providers. [RFP § 12.1.6]

(b) Supplier may not solicit or distribute MCO-specific materials or materials regarding enrollment or disenrollment in an MCO [RFP § 12.7.5];

(c) If Supplier discloses MCO affiliations to a patient, Supplier must list and disclose each MCO with whom they have contracts [RFP § 12.7.7.1];

(d) Although Supplier is not required to display and/or distribute health care materials provided by an MCO, Supplier may (i) display and/or distribute health education materials for all contracted MCOs or (ii) choose not to display and/or distribute for any contracted MCOs. All displayed and/or distributed health education materials shall meet the following requirements:

  (i) Health education posters cannot be larger than 16" x 24";
  (ii) Children's books donated by MCOs must be in common areas;
  (iii) Materials may include an MCOs name, logo, phone number and web site; and
  (iv) Supplier can choose which items to display as long the distribution and display of items from each contracted MCO is equitable [RFP § 12.7.7.2].

(e) Supplier may display marketing materials for MCOs, provided that such materials are conspicuously and equitably posted, in both size and type set, for all contracted MCOs [RFP § 12.7.7.3];

(f) Supplier may display MCO participation stickers, but Supplier must display stickers for all contracted MCOs or choose not to display stickers for any contracted MCOs. Stickers indicating that Supplier participates with a particular MCO cannot be larger than 5" x 7" and cannot indicate anything more than "the MCO is accepted or welcomed here" [RFP § 12.7.7.4-.5];

(g) Supplier may inform patients of the benefits, services and specialty care services offered through the MCOs in which they participate; however, Supplier shall not recommend one MCO over another MCO, offer patients incentives for selecting one MCO over another or assist a patient in decided to select a specific MCO in any way, including, but not limited to, faxing, using the office phone or using a computer in the office [RFP § 12.7.7.6]; and

(h) Supplier shall not display nor distribute any branded materials instructing Members on how to change an MCO; rather, Supplier may only refer Members directly to the Enrollment Broker for needed assistance [RFP § 12.7.7.8].

4.24 Mainstreaming. When applicable, Supplier shall accept Members for treatment and not intentionally segregate Members in any way from other persons receiving services. Supplier shall provide Covered Services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, gender identity or physical or behavioral disability, except where medically indicated. To ensure mainstreaming of Members, Supplier shall comply with the non-discrimination provisions of the Agreement and may not engage in prohibited practices, including, but not limited to:

(a) Denying or not providing a Covered Service or availability of a facility to a Member;

(b) Providing a Covered Service to a Member that is different, or is provided in a different manner or at a different time, from that provided to other Members, public or private patients or the public at large;

(c) Discriminatory practices with regard to Members such as separate waiting rooms, separate appointment days, separate physical locations or preference to private pay or Medicaid FFS patients; and

(d) Excluding treatment or placement of Members for authorized BHS solely on the basis of state agency (DCFS, OJJ, etc.) involvement or referral.

[RFP § 7.7].

5. TERM AND TERMINATION

5.1 Termination for Failure to Re-credential. Supplier shall be subject to re-credentialing by Company during the term of the Agreement. If Supplier fails to submit all appropriate documents for re-credentialing as required under the Agreement or if Supplier's re-credentialing materials are not received by Company, the Agreement may be terminated within thirty (30) days of expiration of Supplier's current credentialing. [RFP § 7.14.1.1.2].

5.2 Termination for Cause. The Parties agree and understand that if the Agreement is terminated for cause, the effective date of such termination may be extended to provide adequate notice to DHH, or to otherwise comply with the requirements of the State Contract or applicable law. [RFP § 7.11].

5.3 Immediate Termination. Company may terminate this Agreement immediately at any time upon the following events:

(a) Supplier's actions or the actions of Supplier's subcontractor(s) pose a serious threat to the health of Members enrolled with Company; [RFP §25.54]

(b) In the event DHH determines that Company has become financially unstable and terminates the State Contract between Company and DHH; [RFP §25.55] and

(c) Supplier fails to disclose any ownership changes within thirty-five (35) calendar days as required by 42 C.F.R. § 455.104 or violates any provision therein. [RFP §§ 7.15.2.8.3.34 & 25.55].

5.4 Termination Without Cause. Either Party may terminate the Agreement without cause by providing ninety (90) days advance written notice to the other Party; however, such shorter periods as applicable under state law and/or the Healthy Louisiana program to Supplier, where Supplier is not a group or hospital. [RFP § 7.11.7].

5.5 Patient Notification Upon Termination. In the event the Agreement is terminated and to the extent applicable, Supplier may notify his or her patients of the change in status and the impact of such change on the patient on the date of termination. Supplier shall continue to see current patients enrolled with Company until the Agreement is terminated, according to all terms and conditions specified in the Agreement. [RFP § 12.7.7.7].

6. GENERAL PROVISIONS

6.1 Disputes. Company and Supplier shall be responsible for resolving any disputes that may arise between the Parties. Supplier's rights to appeal a Claims dispute under the Agreement are set forth in the Provider Manual, as applicable. The Parties agree that no dispute shall disrupt or interfere with the provisions of services to Members. [RFP § 7.2.8.3.22; Appendix O, # 36].

6.2 No Assignment. Unless otherwise provided in the Agreement, Supplier shall not assign any of its duties and/or responsibilities under the Agreement and the State Contract without the prior written consent of MCO. [RFP § 22.6].

6.3 Incorporation of Contractual Requirements, Laws, Guidance and Regulations. The Agreement incorporates and Supplier agrees to adhere to the requirements of all applicable federal and state laws, administrative guidance, rules or regulations, including, but not limited to, Company's provider manual, the Service Definitions Manual, State Contract (specifically including all terms and conditions set forth in Section 25), Medicaid State Plan and contract between DHH and Company. Any revisions or amendments thereto shall automatically be incorporated into the Agreement as they become effective. [RFP §§ 7.13.10 & 7.15.2.8.3.16; Appendix O, # 1 & 35].

6.4 Modifications and Amendments. No modification, alteration, variation, waiver, extension of termination date, early termination of the Agreement or change of any provision of the Agreement shall be made unless such modification is reduced to writing, duly signed and attached as a written amendment to the Agreement; however, Company may provide amendments by written notification through Company bulletins, if mutually agreed to by the Parties and with prior notice to DHH. [Appendix O, #5-6].

If the modification or change constitutes a Material Change affecting Company's ability to deliver or administer health care services, prior approval is required by DHH of at least thirty (30) days in advance of the proposed change implementation. Notwithstanding the foregoing, the Parties acknowledge that the Agreement has been executed based upon a draft of the State Contract and related materials and that the provisions of such documents may be revised prior to the Effective Date. The Agreement shall be automatically amended to conform to the terms and provisions of the final State Contract and related materials. In the event of any inconsistency between the terms of the Agreement and the terms of the final requirements for provider agreements as set forth in the final State Contract and related materials, the terms of the final State Contract and the Policies shall control and take precedence. [RFP §§ 7.6 & 7.13.5].

6.5 Entire Agreement. The Agreement, including the State Contract, any DHH guidance or materials, schedules, appendices, exhibits and/or addenda (which may be provided upon request), constitutes the complete and sole contract, and all terms and conditions, 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 the 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. [RFP § 2.3.2; Appendix O, #4].

6.6 Non-Discrimination. Supplier and Company agree that no person, on the grounds of physical or behavioral disability, age, race, color, creed, religion, sex, sexual orientation/preference, marital status, national origin ancestry or basis, program membership of health or income status for health care services shall be excluded from participation in, or be denied benefits of the Government Program administered by Company. Supplier shall post notices of non-discrimination in conspicuous places, available to all employees and applicants. [RFP §§ 7.7.2, 12.13.3.6 & 25.3, *et al*].

6.7 Indemnification and Hold Harmless. Unless Supplier is a state agency, Supplier shall indemnify, defend, protect and hold harmless DHH and any of its officers, agents and employees from:

(a) Any claims for damages or losses arising from services rendered by any contractor, person or firm performing or supplying services, materials or supplies for Supplier in connection with the performance of the Agreement;

(b) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by Supplier, its agents, officers, employees or contractors in the performance of the Agreement;

(c) Any claims for damages or losses resulting to any person or firm injured or damaged by Supplier, its agents, officers, employees, or contractors by Supplier's publication, translation, reproduction, delivery, performance, use or disposition of any data processed under the Agreement in a manner not authorized by the Agreement or by federal or state regulations or statutes;

(d) Any failure of Supplier, its agents, officers, employees or contractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;

(e) Any claims for damages, losses or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims or damages specified above; and

(f) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or their agents, officers or employees, through the intentional conduct, negligence or omission of Supplier, its agents, officers, employees or contractors.

[RFP § 25.25; Appendix O, #32].

In the event that, due to circumstances not reasonably within the control of Supplier, Company or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither Supplier, Company, DHH or contractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the Agreement remains in full force and effect, Supplier shall be liable for the Covered Services required to be provided or arranged for in accordance with the Agreement. [RFP § 25.25.2].

DHH will provide prompt notice of any claim against it that is subject to indemnification by Supplier under the Agreement. Supplier may, at its sole option, assume the defense of any such claim. DHH may not settle any claim subject to indemnification hereunder without the advance written consent of Supplier, which shall not be unreasonably withheld. [RFP § 25.25.3; Appendix O, # 32].

6.8 Conflict of Interest. Supplier may not contract with Company unless such safeguards at least equal to federal safeguards (41 U.S.C. 423) are in place per the state Medicaid director letter dated December 30, 1997 and 1932 (d)(3) of the Social Security Act addressing the 1932 Medicaid State Plan and the default enrollment process under the SPA option. [RFP § 25.8; Appendix O, #37].

6.9 Severability. If any provision or requirement of the Agreement, including items incorporated by reference, is determined by DHH to conflict with the State Contract between DHH and Company, such requirement shall be null and void and all other provisions shall remain in full force and effect. In addition, if the laws or regulations governing the State Contract should be amended or judicially interpreted as to render fulfillment of the State Contract impossible or economically infeasible, such that Company is discharged from its obligations under the State Contract, Supplier shall also be discharged from further obligations created under the terms of the Agreement. [RFP § 25.51; Appendix O, #9].

6.10 Non Exclusive Clause. Nothing in the Agreement shall be construed to prohibit Supplier from entering into a contract or arrangement with any other health plan or managed care entity. Nor shall anything in the Agreement be construed to prohibit Company from entering into a contract or arrangement with any other provider. Company shall not advertise or otherwise hold itself out as having an exclusive relationship with Supplier or any service provider. [RFP § 7.13.1; Appendix O, #41].

6.11 Transfer of Agreement. The Agreement may not be transferred by Supplier without prior written consent of Company. However, Supplier assigns to the State of Louisiana any and all rights or claims he, she or it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including, but not limited to, product units purchased or reimbursed under Healthy Louisiana. For purposes of this assignment clause, Supplier shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries. [La. Atty. Gen. antitrust directive, 8/28/15].

7. DELEGATION AND ANCILLARY SERVICES

7.1 Delegation. Supplier shall not enter into any subsequent agreements with subcontractors for any of the work contemplated under the Agreement without Company's prior approval. [Appendix O, #8]. In the event that duties are delegated hereunder, Company shall:

(a) Along with Supplier, oversee all of subcontractor's performance for delegated activities;
(b) Ensure, along with Supplier (if applicable), that subcontracts fulfill the requirements of 42 C.F.R. Part 438, as appropriate to the delegated activities;
(c) Submit to DHH who has the right to review, approve and/or disapprove or any and all subcontracts entered into for the provision of services hereunder;
(d) Evaluate, in its discretion, subcontractor's ability to perform the activities to be delegated;
(e) Require a written agreement with subcontractor, specifying the activities and reporting responsibilities delegated to subcontractor, including revocation of delegation, contract termination or imposition of sanctions for subcontractor's inadequate performance;
(f) Monitor subcontractor's performance on an ongoing basis, subject to formal review, according to a periodic schedule consistent with industry standards;
(g) Identify areas of deficiencies or improvement and take corrective action; and
(h) Deny payments for provider preventable conditions, per the State Contract.

[RFP §§ 7.13.3-.4].

7.2 Credentialing. If applicable, the Agreement shall set forth a written description of the delegation of credentialing activities delegated to subcontractor. The subcontractor must provide assurance, at all times during the Agreement, that all medical professionals are credentialed in accordance with DHH's credentialing requirements and that specialty behavioral health providers are certified in accordance with DHH's certification requirements. The Parties and

subcontractor understand that DHH shall have final approval over a delegated entity, including the delegation of credentialing and certification of specialized behavioral health providers. [RFP §§ 7.14.6-.7]. The Parties agree that subcontractor shall:

(a) Load provider files into its Claims processing system within thirty (30) calendar days of receipt [RFP § 7.14.8];

(b) Notify Company immediately, or within such other time required by DHH, if a provider credentialing application is denied for reasons related to program integrity or otherwise limits the ability of a provider to participate for program integrity reasons[RFP § 7.14.9];

(c) Process re-credentialing not less than once every three (3) years [RFP § 7.14.10];

(d) Adopt policies or implement Company's policies and procedures to approve, terminate or suspend providers to ensure compliance with the Agreement and the State Contract [RFP § 7.14.11];

(e) Implement and/or assist with a provider dispute or appeal process [RFP § 7.14.13]; and

(f) Develop and implement a mechanism, subject to DHH approval, for reporting quality deficiencies which result in suspension or termination of a network provider. This process shall be submitted for review and approval thirty (30) days from the date the State Contract is signed and at the time of any change. [RFP § 7.14.12].

Supplier and/or subcontractor agrees and understands that, pursuant to the State Contract, DHH and/or the State of Louisiana or its representative, reserved the right to contract with a single Credential Verification Organization ("CVO") under the State Contract. In such event, Supplier and/or subcontractor agree that the Agreement shall be terminated concurrent with the minimum notice of ninety (90) days as provided to Company by DHH of such implementation of any CVO contract. [RFP § 7.14.14].

7.3 Audits. In addition to the provisions set forth above, Supplier shall comply with audits, inspections and reviews in accordance with Company's Provider Manual, including any review the Company of DHH may conduct. [RFP §§ 7.15.2.8.3.24 & 17.11.2.5].

7.4 Pharmacy Services and Pharmacy Benefit Managers ("PBMs"). "Pharmacy Services" are defined as the provision of pharmacy benefits under the State Contract, including the dispensing of prescription drugs by pharmacies and the third-party administration of drug programs by a PBM. PBMs and Suppliers of Pharmacy Services shall meet the following requirements:

(a) Provide a pharmacy network that complies with DHH requirements, including a network of only licensed and registered pharmacies that conform to the Louisiana Board of Pharmacy rules regarding records maintained by a pharmacy and not prohibit any pharmacy or pharmacist participating in the Medicaid program as a network provider if the pharmacy or pharmacist is licensed and in good

standing with the Louisiana Board of Pharmacy and accepts the terms and conditions of the contract offered to them. [RFP §§ 7.17.1.1-.2].

(b) Assist Company in maintaining an up-to-date pharmacy provider directory on its website for public access. {RFP §7.17.1.3].

(c) Maintain a network audit program approved by DHH that includes, at a minimum, random audits (that may not be contingency fee based audits) to determine provider compliance with the program policies, procedures and limitations outlined in the provider's contract. [RFP § 7.17.1.5].

(d) Educate network providers regarding online access to the formulary and preferred drug list and provide provider education on claims processing and payment policies and procedures [RFP §§ 7.17.1.6-.7].

(e) If negotiating ingredient cost-reimbursement in provider contracts, PBM or Supplier shall [RFP § 7.17.1.8]:

1. Pay a per-prescription dispensing fee at a rate no less than $2.50 to all "local pharmacies" as defined in Act 399 of the 2015 Regular Session of the Louisiana Legislature;
2. Add any state imposed provider fees for Pharmacy Services on top of the minimum dispensing fee required by DHH;
3. Update ingredient costs of medications at least weekly,
4. Make drug pricing lists available to pharmacies for review;
5. Afford individual pharmacies a change to appeal inadequate reimbursement; and
6. Provide for a "local pharmacy" appeals process in accordance with Act 399 of the 2015 Regular Session of the Louisiana Legislature and as specified by DHH.

(f) PBM or Supplier shall not charge pharmacy providers claims processing or provider enrollment fees, excluding sanctions. [RFP § 7.17.1.9].

(g) PBM or Supplier shall not require Members to use a mail service pharmacy and shall not charge Members anything above applicable copays (i.e., shipping and handling fees). [RFP § 7.17.2].

(h) With Company's approval, PBM or Supplier may limit the distribution of specialty drugs, as defined by the State Contract, to a network of specialty pharmacies that meet reasonable requirements to distribute specialty drugs and are willing to accept the terms of the provider agreement. [RFP §7.17.3].

(i) PBM and/or Supplier agrees and understands that Company is required under the State Contract to disclose to DHH all financial terms and arrangements for remuneration of any kind that apply between Company and Company's pharmacy supplier, other subcontractor, prescription drug wholesaler, manufacturer or labeler, including, without limitation, formulary management, educational support, claims processing, pharmacy network fees, drug product sales, pricing agreements, data sales fees and any other fees. Pursuant to the State Contract, PBM and/or Supplier agrees and understands that DHH or state auditors may audit such information at any time. DHH agrees to maintain the confidentiality of information disclosed by PBM or Supplier to Company to the extent that such information is confidential under state and/or federal law. [RFP § 5.15].

7.5 Referral Requirements. Supplier shall not require a PCP referral for in-network eye care and vision services. [RFP § 8.5.4.2].

7.6 Non-Emergency Medical Transportation ("NEMT"). Supplier agrees to comply with Company's NEMT policies and Louisiana Medicaid guidelines to ensure Members' access to care. Supplier must be available to provide services to Members upon 48 hours advance notice. Supplier shall schedule the transportation so that the Member arrives on time but no sooner than one (1) hour before the appointment, does not have to wait more than one (1) hour after the conclusion of the treatment for transportation home and is not picked up prior to completion of the Member's treatment. [RFP §§ 6.23.3 & 7.8.9.1-.2].

Louisiana State Compliance Addendum

This Louisiana State Compliance Addendum (the "State Compliance Addendum") is incorporated by reference in the Agreement. This State Compliance Addendum shall supplement the Addendum and control, unless such provision conflicts with the State Contract or Louisiana Department of Health and Hospitals' ("DHH") rules and regulations.

For purposes of this State Compliance Addendum, the term "Supplier" shall mean the individual or entity executing the Agreement, and may include a health care physician, provider, group, facility, hospital, individual or entity. Capitalized terms used in this State Compliance Addendum that are not defined herein shall have the meaning set forth in the Addendum and/or the main Agreement.

To the extent applicable to the services Supplier performed under the Agreement, the parties agree as follows:

1.0 SUPPLIER SERVICES AND OBLIGATIONS

1.1 Non-Compliant Members. If Supplier desires to discharge a Member, Supplier shall follow the rules and Policies of Company. Supplier agrees to continue to provide Covered Services to such Member under the same terms and conditions as set forth in the Agreement until such time as Company makes appropriate arrangements for another Participating Provider to accept such Member as a patient.

1.2 Emergency Management Plan. When applicable, Supplier agrees to become familiar with and abide by the terms and procedures set forth in Company's emergency or catastrophe response, management or operations plan as required and approved by DHH, Louisiana Department of Insurance ("LDI") or other governmental body, including, but not limited to, the execution of a memorandum of understanding with Company if Supplier is located in a parish where services may be provided to evacuated Members, when required by Company. Supplier acknowledges and understands that said plan is confidential and the Proprietary Information of Company. This provision shall survive termination of the Agreement. La. R.S. 22:572.

2.0 COMPANY OBLIGATIONS

2.1 No Interference by Company. Company agrees that it will not prohibit or restrict Supplier from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of Company which may negatively impact upon the quality of, or access to patient care in accordance with state and federal law. La. R.S. 22:1007; 42 C.F.R. § 438.102(a)(1)(i)-(iv).

2.2 Open Communication with Members. Nothing in this Agreement shall be construed to impede the open clinical dialogue and clinical communication between Supplier and Members or otherwise interfere with Supplier's ability to communicate with a Member regarding his or her health care, including but not limited to communications regarding treatment options, medical alternatives or other coverage arrangements. Company encourages Supplier to freely communicate with Members about clinical treatment options, including medications, available to them, regardless of benefit coverage limitations. Notwithstanding the foregoing, Supplier shall not solicit for alternative coverage arrangements for the primary purpose of securing financial gain. La. R.S. 22:1007(B).

2.3 Required Disclosures by Company. To ensure that Company does not have any "silent PPO" arrangements, Company shall disclose within forty-five (45) days following the written request of Supplier:

(a) The list of clients or other payors entitled to a contracted rate under Company's contract with Supplier; and

(b) The specific clients or other payors by whom a contracted rate was applied to a particular claim under Company's contract with Supplier.

La. R.S. 40:2203.1.

2.4 Communication of Plan and Health Benefit Program Changes. In order to prevent or reduce the risk of misinformation, Supplier agrees that Company shall have the exclusive right and responsibility to communicate changes in the Plan or other health benefit programs to Members. It is understood, however, that this shall not be interpreted as restricting in any way Supplier's ability to freely communicate medical advice to Members, and shall not be construed as prohibiting any communication subject to the protections of La. R.S. 22:1007.

3.0 CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Compensation; Reimbursement Rates. The payments rendered or to be rendered to Suppliers under this Agreement, as may be amended from time to time, shall be deemed and shall remain confidential information. This provision shall survive any termination of the Agreement. La. R.S. 22:263(F).

3.2 Prohibited Inducements. Nothing in this Agreement shall be construed to provide an incentive or specific payment from Company, directly, indirectly or in any form, to Supplier as an inducement to deny, reduce, limit or delay Medically Necessary and appropriate services provided with respect to a specific Member or group of Members with similar medical conditions. La. R.S. 22:263(E); La. R.S. 22:1008.

4.0 TERM AND TERMINATION

4.1 Continuity of Care. In the event the Agreement is terminated, Supplier shall notify Company of any Member who has begun a course of treatment by Supplier before the effective date of the termination. Upon such notice, Company shall notify the Member of the termination of Supplier from Company's network and the Member's right to continuity of care. Upon termination of this Agreement, the following provisions shall apply:

(a) In the event Member has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth (24th) week of pregnancy, Member shall be allowed to continue receiving Covered Services, subject to the consent of Supplier, through delivery and postpartum care related to the pregnancy and delivery.

(b) In the event a Member has been diagnosed with a life-threatening illness (a severe, serious or acute condition for which death is probable), Member shall be allowed to continue receiving Covered Services, subject to the consent of Supplier, until the course of treatment is completed, not to exceed three (3) months from the effective date of such termination.

(c) In the event Supplier advises Company of a Member who meets the criteria of the foregoing paragraphs, Company shall continue payment to Supplier at the rate that was in effect prior to the termination of this Agreement. In addition, the contractual requirements for Supplier to follow Company's utilization management and quality management policies and procedures, when applicable, shall remain in effect for the applicable period described above.

(d) Supplier shall be prohibited from discount billing and dual billing as prohibited by the Louisiana Health Care Consumer Billing and Disclosure Protection Act (La. R.S. 22:1871 *et seq.*); however, Supplier shall be deemed to be a contracted Supplier with Company for payment purposes for services provided pursuant to this Section.

La. R.S. 22:1005(B).

4.2 Continuity of Care; Exceptions. Notwithstanding the foregoing, the continuity of care provisions above shall not apply when:

(a) The reason for such termination is due to suspension, revocation, or applicable restriction of the Supplier's license to practice in this state by the Louisiana State Board of Medical Examiners or for another documented reason related to quality of care;

(b) The Member chooses to change Suppliers;

(c) The Member moves out of the geographic service area of the health care provider or health insurance issuer; and

(d) The Member requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

La. R.S. 22:1005(C).

5.0 DISPUTE RESOLUTION

5.1 Grievance Procedure. A grievance procedure has been established for the processing of any Member complaints regarding Covered Services furnished by Supplier. Supplier shall comply with and, subject to Supplier's rights of appeal, shall be bound by such grievance procedure. In addition, Supplier shall adhere to all appeal/expedited appeal procedures for Medicare and/or Medicaid beneficiaries, including the gathering and forwarding of information on appeals to the Company, as necessary. La. R.S. 22:263(A)(3).

5.2 Assistance with Member Grievance Dispute Resolution. When required by Company or applicable law, Supplier shall display notices of a Member's right to appeal any adverse action affecting Covered Services in public areas of Supplier's facility(ies). Upon request from Supplier, Company shall furnish Supplier with additional copies of public notices and appeal forms. At Supplier's discretion, Supplier may file a grievance on behalf of a Member; however, Supplier shall adhere to the requirements and grievance and appeals procedures outlined by Company, CMS, DHH or other governmental body. Notwithstanding any Company, CMS or DHH grievance and appeal process, rule or contractual provision to the contrary, Supplier is not precluded from pursuing relief through a court of appropriate jurisdiction for the resolution of a provider initiated grievance or appeal. With respect to emergency appeals and when appropriate, Supplier shall comply with all appeal processes and shall assist Members by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for Company and/or state level review. La. R.S. 22:267.

Exhibit B-12

Aetna Better Health Inc.

d/b/a Aetna Better Health of Ohio

Medicaid Addendum

This Addendum supplements the Base Contract between **Aetna Life Insurance Company on behalf of Aetna Better Health Inc. d/b/a Aetna Better Health of Ohio ("Aetna Better Health")** and Cotiviti LLC effective April 1, 2017 and runs concurrently with the terms of the Base Contract. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members.

ADDENDUM DEFINITIONS

Agreement/Base Contract	The contract between the MCP and the Provider.
Managed Care Plan (MCP)	A Medicaid managed care plan that enters into a provider agreement with ODM to serve Medicaid consumers, which may include dually-eligible consumers who are enrolled in MyCare Ohio Plans.
Medicaid	Medical assistance provided under a state plan approved under Title XIX of the Social Security Act.
Member	A Medicaid recipient enrolled under the care management system pursuant to ORC 5167.
OAC	Ohio Administrative Code.
ODM	Ohio Department of Medicaid.
ORC	Ohio Revised Code.
Provider	A hospital, health care facility, physician, dentist, pharmacy or otherwise licensed, certified, appropriate individual or entity, which is authorized to or may be entitled to reimbursement for health care services rendered to an MCP's member.

ADDENDUM PROVISIONS

The provisions of this Medicaid Addendum supersede any language to the contrary which may appear elsewhere in the Base Contract.

Participating providers providing health care services to **Aetna Better Health's** Medicaid and/or MyCare members agree to abide by all of the following specific terms:

1. Provider agrees with the exception of any member co-payments the MCP elected to implement in accordance with OAC rule 5160-26-12, the MCP's payment constitutes payment in full for any covered service and will not charge the member or ODM any co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise. This agreement does not prohibit Nursing Facilities (NFs) or waiver entities from collecting patient liability payments from members, as specified in OAC rule 5160:1-3-24, or Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) from submitting claims for supplemental payments to ODM as specified in OAC rules 5160-28-07 and 5160-16-05.

    A. MCP shall notify the provider whether the MCP elected to implement any member co-payments and, if applicable, under what circumstances member co-payments are imposed in accordance with OAC rule 5160-26-12.

    B. Provider agrees member notification regarding any applicable co-payment amounts must be carried out in accordance with OAC rule 5160-26-12.

2. Provider agrees not to hold liable ODM and the member in the event the MCP cannot or will not pay for covered services performed by the provider pursuant to the Base Contract with the exceptions that:

    A. FQHCs and RHCs may be reimbursed by ODM in the event of MCP insolvency pursuant to Section 1902(bb) of the Social Security Act.

    B. The provider may bill the member when the MCP denied prior authorization or referral for the services and the following conditions are met:

        i. The provider notified the member of the financial liability in advance of service delivery;

        ii. The notification, by the provider, was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement

signed by all patients is not sufficient for this purpose; and

iii. The notification is dated and signed by the member.

3. Provider agrees to cooperate with the MCP's quality assessment and performance improvement (QAPI) program in all the MCP's provider subcontracts and employment agreements for physician and nonphysician providers.

4. The MCP shall disseminate written policies including detailed information about the False Claims Act and other provisions named in 42 U.S.C. Section 1396a(a)(68), any related State laws pertaining to civil or criminal penalties, whistleblower protections under such laws, as well as the MCP's policies and procedures for detecting and preventing fraud, waste and abuse; and the provider agrees to abide by the MCP's written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.

5. Provider agrees to cooperate with the ODM external quality review as required by 42 C.F.R. 438.358, and on-site audits, as deemed necessary based on ODM's periodic analysis of financial, utilization, provider panel, and other information in OAC Chapter 5160, including rule 5160-26-07.

6. The terms of the Base Contract relating to the beginning date and expiration date or automatic renewal clause, as well as the applicable methods of extension, renegotiation and termination apply to this Addendum.

7. Notwithstanding Item 6 of this Addendum, the MCP must give the provider at least sixty days prior notice for the nonrenewal or termination of the Base Contract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the Base Contract be terminated sooner.

8. Notwithstanding Item 6 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:

   A. The provider gives the MCP at least fifty-five days prior notice for the nonrenewal or termination of the Base Contract. The effective date for the nonrenewal or termination must be the last day of the month; or

   B. ODM proposed action in accordance with OAC Chapter 5160, including rule 5160-26-10(G), regardless whether the action is appealed. The provider's nonrenewal or termination notice must be received by the MCP within fifteen working days prior to the end of the month in which the provider is proposing nonrenewal or termination. If the notice is not received by this date, the provider must extend the nonrenewal or termination date to the last day of the subsequent month.

9. The procedures to be employed upon the ending, nonrenewal, or termination specified in the Base Contract, apply to this Addendum including an agreement to promptly supply all records necessary for the settlement of outstanding claims.

10. Notwithstanding Items 7 and 8 of this Addendum, in the event of a hospital provider's proposed non-renewal or termination of the Base Contract, the hospital provider agrees to notify in writing all providers who have admitting privileges at the hospital of the impending non-renewal or termination of the Base Contract and the last date the hospital will provide services to members under the Base Contract. This notice must be sent at least forty-five days prior to the effective date of the proposed non-renewal or termination. If the hospital provider issues fewer than forty-five days prior notice to the MCP, the notice to providers who have admitting privileges at the hospital must be sent within one working day of the hospital provider issuing notice of non-renewal or termination of the Base Contract.

11. Provider agrees to release to the MCP any information necessary for the MCP to perform any of its obligations under the ODM provider agreement, including, but not limited to, compliance with reporting and quality assurance requirements. Provider agrees the released information will be shared with ODM upon request to the MCP.

12. Provider must supply, upon request, the business transaction information required under 42 C.F.R. 455.105.

13. Provider and all employees of the provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the Base Contract and provider and all employees of the provider are not excluded from participating in federally funded health care programs.

14. If the provider is a Medicaid provider, provider must meet the qualifications specified in OAC Chapter 5160, including rule 5160-26-05(C).

15. All laboratory testing sites providing services to members must have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or a certificate of registration along with a CLIA identification number.

16. Home health providers must meet the eligible provider requirements specified in OAC Chapter 5160-12 and comply with the requirements for home care dependent adults as specified in section 121.36 of the Ohio Revised Code.

17. Provider shall be compensated pursuant to the method and in the amounts specified in Exhibit A, Statement of Work, Section 13.

18. Provider agrees to provide services to all eligible Medicaid consumer populations as specified in the Ohio Department of Medicaid Provider Agreement. NA:

☐Medicaid non-dual populations ☐MyCare Ohio Medicare/Medicaid populations

19. Provider agrees to provide services to MyCare Ohio consumers within the designated service area.

20. If the provider is a third party administrator (TPA), the provider agrees to include all elements of OAC rule 5160-26-05(D) in its subcontracts and will ensure that its subcontractors will forward information to ODM as requested.

21. Provider agrees to provide services as enumerated in **Attachment D** of this Addendum (within the provider's scope of practice).

22. Provider agrees to serve members through the last day the Base Contract is in effect.

23. Any amendment to the Attachment D and (and the Schedule, Exhibit, and/or Appendix) specified in item 17 of the addendum must be agreed to in writing by both parties.

24. If provider is a primary care provider (PCP), provider agrees to participate in the care coordination requirements outlined in OAC Chapter 5160, including rule 5160-26-03.1.

25. If provider is a hospital or hospital system, the Addendum must include the completed ODM Hospital Services Form, Attachment C of this addendum, which specifies which services of the hospital are included in the Base Contract.

26. MCP agrees not to prohibit, or otherwise restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following:

    A. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

    B. Any information the member needs in order to decide among all relevant treatment options.

    C. The risks, benefits, and consequences of treatment versus non-treatment.

    D. 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.

27. Provider agrees in providing health care services to members to identify and where indicated arrange, pursuant to the mutually agreed upon procedures between the MCP and provider for the following at no cost to the member:

    A. Sign language services.

B. Oral interpretation and oral translation services.

28. MCP agrees to fulfill the provider's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the provider bills a member due to the MCP's denial of payment of a Medicaid service, as specified in OAC Chapter 5160 including rule 5160-26-08.4, utilizing the procedures and forms as specified in OAC rule 5101:6-2-35.

29. Provider agrees to contact the MCP's designated twenty-four-hour post-stabilization services phone line to request authorization to provide post-stabilization services in accordance with OAC Chapter 5160, including rule 5160-26-03(G).

30. Provider agrees not to identify the addressee as a Medicaid consumer on the outside of the envelope when contacting members by mail.

31. **Provider agrees not to bill members for missed appointments.**

32. Provider shall not discriminate in the delivery of services based on the member's race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status, or need for health services.

33. Provider, in performance of the subcontract or in the hiring of any employees for the performance of services under the contract, shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, health status or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

34. Provider shall not in any manner discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the subcontract on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, health status, or ancestry.

35. Provider shall be bound by the same standards of confidentiality which apply to ODM and the state of Ohio as described in OAC rule 5160:1-1-51.1 and 45 CFR Parts 160 and 164, including standards for unauthorized uses of or disclosures of protected health information (PHI).

36. Provider agrees their applicable facilities and records will be open to inspection by the MCP, ODM or its designee, or other entities as specified in OAC rule 5160-26-06.

37. Provider agrees the Base Contract and Addendum are governed by, and are construed in accordance with all applicable laws, regulations, and contractual obligations of the MCP.

A. ODM will notify the MCP and the MCP shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCP.

B. This Addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.

C. The MCP shall notify the provider of all applicable contractual obligations.

38. Provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC Chapter 5160-26.

39. Provider must retain and agrees to allow the MCP access to all member medical records for a period of not fewer than eight years from the date of service or until any audit initiated within the eight year period is completed and allow access to all record keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in OAC rule 5160-26-06. At least three of the eight year-period of documentation must be readily available.

40. Provider agrees to make patient medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the patient.

41. Provider agrees that if the base contract, with the MCP, provides for assignment to another entity, no assignment, in whole or in part, shall take effect without sixty days prior notice to the MCP.

42. Provider agrees to immediately forward any information regarding a member appeal or grievance, as defined in OAC 5160-26-08.4 or 5160-58-08.4, for processing.

The Ohio Department of Medicaid permits changes to Attachments A, B, C and/or D by mutual written agreement of both parties and without renegotiation of the Base Contract or this Addendum.

Signatures	
MCP Name: **Aetna Life Insurance Company on behalf of Aetna Better Health Inc. d/b/a Aetna Better Health of Ohio**	Provider Name: Cotiviti LLC

Marc Marini (Jul 24, 2017)

Authorized Signature

Jonathan Olefson (Jul 23, 2017)

Authorized Signature

Marc Marini	Jonathan Olefson
Print Name	Print Name
Marc Marini	General Counsel
Title	Title
Jul 24, 2017	Jul 23, 2017
Date	Date

Attachment A: Primary Care Provider Attestation

To be completed for Primary Care Providers (PCPs) only. 'Capacity' represents the maximum number of the MCP's Medicaid-only members the primary care provider (PCP) agrees to serve. PCPs individually or as part of a group, must serve a minimum of 50 of the MCP's Medicaid members at each practice site in order to be listed in the MCP's provider directory. **List all PCP names are contracted with to provide services to Medicaid Members.**

Practice Site		**Physician Name**	**Capacity Max.**
1.	Group Name	Name	Maximum #
	Address	Name	Maximum #
	City Zip Code	Name	Maximum #
		Name	Maximum #
		Name	Maximum #

2.	Group Name	Name	Maximum #
	Address	Name	Maximum #
	City Zip Code	Name	Maximum #
		Name	Maximum #
		Name	Maximum #

3.	Group Name	Name	Maximum #
	Address	Name	Maximum #
	City Zip Code	Name	Maximum #

Name	Maximum #
Name	Maximum #

Total: _____

If the practice has more than two locations or more than five PCPs at a location, provide the information requested above in an attached document titled 'Attachment A.' If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3) and the last page must be signed by the provider and the MCP.

Signatures	
MCP Name: Marc Marini (Jul 21, 2017)	Provider Name: Jonathan Olefson (Jul 17, 2017)
Signature:	Signature:
Printed Name: Marc Marini	Printed Name: Jonathan Olefson
Title: VP, CPO	Title: General Counsel
Date: Jul 21, 2017	Date: Jul 17, 2017

Attachment B: Non-Primary Care Providers Only

List all **non-PCP** names are contracted with to provide services to Medicaid Members.

PRACTICE SITE	PROVIDER NAME	SPECIALTY
1. GROUP NAME	NAME	SPECIALTY
ADDRESS	NAME	SPECIALTY
CITY, ZIP CODE	NAME	SPECIALTY
2. GROUP NAME	NAME	SPECIALTY
ADDRESS	NAME	SPECIALTY
CITY, ZIP CODE	NAME	SPECIALTY
3. GROUP NAME	NAME	SPECIALTY
ADDRESS	NAME	SPECIALTY
CITY, ZIP CODE	NAME	SPECIALTY

If the practice has more than three locations or more than (5) providers at a location, please provide the requested information in a document titled 'Attachment B'. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3) and the last page must be signed by the provider and the MCP.

Signatures

MCP Name:	Provider Name:
Signature: Marc Marini (Jul 21, 2017)	Signature: Jonathan Olefson (Jul 17, 2017)
Printed Name: Marc Marini	Printed Name: Jonathan Olefson
Title: VP, CPO	Title: General Counsel
Date: Jul 21, 2017	Date: Jul 17, 2017

Attachment C: Hospital Services Form

The provider must complete a copy of this form for each hospital covered by the terms and conditions of this addendum. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3) and the signature block must be included on the each page.

1. Name and Address

Hospital Name:
Address: (including county):

2. Hospital Services Categories

Please check the applicable line for each category of service the above-named hospital covers.

☐ Adult General Medical/Surgical Services	☐ Midwife Services
☐ Pediatric General Medical/Surgical Services	☐ Outpatient Surgery
☐ Obstetrical Services	☐ Pediatric Intensive Care
☐ Nursery Services	☐ Special Care
☐ Nursery Services Level 1 & 2	☐ Psychiatric Services
☐ Neonatal Intensive Care -- Level 3	☐ Practitioner Services
☐ Adult Intensive Care	☐ Other

3. Hospital does not provide the following hospital service(s) because of an objection on moral or religious grounds. List Services :

_____
_____
_____
_____
_____

Signatures	
MCP Name:	Provider Name:
Signature: Marc Marini (Jul 21, 2017)	Signature: Jonathan Olefson (Jul 17, 2017)
Printed Name: Marc Marini	Printed Name: Jonathan Olefson
Title: VP, CPO	Title: General Counsel
Date: Jul 21, 2017	Date: Jul 17, 2017

Attachment D: Services Provided

Provider agrees to provide services as enumerated below (specify below):

☐Ambulance transportation	☐Mental health and/or substance abuse services
☐Ambulette transportation	☐Nursing facility services
☐Ambulatory Surgery Center	☐Obstetrical and/or gynecological services
☐Advanced practice nurse services specify:	☐Ophthalmology services
☐Chiropractic services	☐Outpatient hospital services
☐Dental services	☐Physical and occupational therapy
☐Durable medical equipment (DME)	☐Podiatry services
☐Emergency Services	☐Pharmacy
☐Family planning services and supplies	☐Physician services
☐Federally Qualified Health Center services	☐Primary care provider services
☐Home health services/Private Duty Nursing	☐Renal dialysis
☐Hospice care	☐Rural Health Clinic services
☐Medical Imaging	☐Specialty physician services, Specify (e.g., cardiology, allergy, etc.):
☐Inpatient hospital services	☐Speech and hearing services
☐Laboratory services	☐Vision (optical) services, including eyeglasses
☒Other: Data mining and recovery audit services.	

Community Behavioral Health Services (included only in the MyCare Ohio benefit package)

☐Pharmacological Management	☐Ambulatory Detox
☐Behavioral Health Assessment	☐Targeted Case Management for AOD
☐Behavioral Health Counseling and Therapy	☐Intensive Outpatient
☐Crisis Intervention	☐Laboratory urinalysis
☐Partial Hospitalization	☐Med –Somatic
☐Community Psychiatric Support Treatment	☐Methadone Administration

Home and Community Based Services (included only in the MyCare Ohio benefit package)

** indicates service provider types which may be counted in more than 1 county or region. All others may only count in the county where the provider is physically located.*

☐Out of Home Respite Services	☐Waiver Nursing Services
☐Adult Day Health Services	☐Home Delivered Meals*
☐Waiver Transportation*	☐Assisted Living Services
☐Chore Services*	☐Home Care Attendant
☐Social Work Counseling	☐Choices Home Care Attendant
☐Emergency Response Services*	☐Enhanced Community Living Services
☐Home Modification Maintenance and Repair*	☐Nutritional Consultation
☐Personal Care Services	☐Independent Living Assistance
☐Homemaker Services	☐Community Transition Services
☐Pest Control*	☐Alternative Meals Service
☐Home Care Attendant Nursing	
☐Home Medical Equipment and Supplemental Adaptive and Assistive Device Services*	

Signatures	
MCP Name: **Aetna Life Insurance Company on behalf of Aetna Better Health Inc. d/b/a Aetna Better Health of Ohio**	Provider Name: Cotiviti LLC

Marc Marini (Jul 24, 2017)

Authorized Signature

Marc Marini

Print Name

Marc Marini

Jonathan Olefson (Jul 23, 2017)

Authorized Signature

Jonathan Olefson

Print Name

General Counsel

Marc Marini

Title

Jul 24, 2017

Date

General Counsel

Title

Jul 23, 2017

Date

Exhibit B-13

Regulatory Compliance Addendum

Governing Medicare-Medicaid Dual-Eligible Services

(Aetna Better Health of Ohio)

This Regulatory Compliance Addendum Governing Medicare-Medicaid Dual-Eligible Services (the "Duals Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under, as well as the provision of any administrative or health-benefit management services/functions that relate to:

(8) the *Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services, In Partnership with the State of Ohio Department of Medicaid and Aetna Better Health Inc., an Ohio Corporation*, issued on April 13, 2016 (the "Three-Way Contract");

(9) the *Ohio Department of Medicaid MyCare Ohio Provider Agreement for MyCare Ohio Plan*, by and between the Ohio Department of Medicaid ("ODM" or the "State") and Aetna Better Health Inc. d/b/a Aetna Better Health of Ohio (the "Two-Way Contract"); and

(10) any successor contracts to or amendments of any of the foregoing;

to the extent that the terms and conditions of this Duals Addendum are applicable to Provider's services and obligations. The Three-Way Contract and Two-Way Contract collectively govern the program known as the MyCare Ohio Duals Demonstration (the "Demonstration"), under which Aetna Better Health Inc. d/b/a Aetna Better Health of Ohio ("Company") serves as a managed-care organization.

This Duals Addendum is incorporated by reference into the Agreement between Company (or its affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing the Agreement, as identified on the first page of the Agreement (the "Provider"), and Provider must comply with the requirements set forth herein. Note that this Duals Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement, in the Three-Way Contract or Two-Way Contract, and in the policies, procedures, and provider manual of Company (or its affiliate, as the case may be). This Duals Addendum and the Agreement may be revised as directed by the State and/or by the Centers for Medicare and Medicaid Services ("CMS").

For purposes of this Duals Addendum, Company may be referred to as "MCO" or "the MCO" (a/k/a managed care organization), and the individuals who are enrolled with Company under the Demonstration may be referred to as the "Beneficiaries," "Members," or "Enrollees." All capitalized terms not defined in this Duals Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Duals 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 Duals Addendum will govern and control with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract, the Two-Way Contract, and the Demonstration, and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract, the Two-Way Contract, and/or the Demonstration; provided, however, that if there is a conflict between any of the terms of the Agreement (including this Duals Addendum), on the one hand, and the Three-Way Contract, the Two-Way Contract, and/or the State-mandated Medicaid addendum referenced in **Section A** below, on the other, then the latter's terms will govern and control. Except as provided herein, all other provisions of the Agreement not inconsistent with this Duals Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Duals Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Three-Way Contract, the Two-Way Contract, and the remainder of the Agreement.

Provider acknowledges and agrees that all provisions of this Duals Addendum shall apply equally to any employees, independent contractors, subcontractors, downstream entities, or related entities of Provider that provide Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract, the Two-Way Contract, and/or the Demonstration, or that provide administrative or health-benefit management services/functions that relate to those Covered Services or to the Three-Way Contract, the Two-Way Contract, and/or the Demonstration, and Provider represents and warrants that Provider shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Duals Addendum and all applicable laws and regulations.

REQUIREMENTS FOR THE DEMONSTRATION

G. Ohio State Requirements

Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the requirements set forth in Exhibit B-12("Medicaid Addendum") to the Agreement with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract, the Two-Way Contract, and/or the Demonstration, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract, the Two-Way Contract, and/or the Demonstration, and furthermore acknowledges and agrees as follows:

136. To the extent that MCO is delegating to Provider any activities or responsibilities in connection with the Three-Way Contract, the Two-Way Contract, and/or the Demonstration:

a. the Agreement sets forth the sanctions to be imposed for Provider's inadequate performance with respect to those delegated activities or responsibilities, which sanctions specifically include MCO's authority to require Provider's corrective action for any deficiencies or areas for improvement and/or to revoke the delegation if MCO or the ODM determines that the delegation is not in the best interest of the Beneficiaries [OAC 5160-26-05(A)(3)(f)];

b. the Agreement sets forth the sanctions to be imposed for Provider's unauthorized use or disclosure of Beneficiaries' protected health information (PHI) [OAC 5160-26-05(A)(3)(g)]; and

c. all information that is required to be submitted to the ODM in connection with the Three-

Way Contract, the Two-Way Contract, and/or the Demonstration shall be submitted directly by the MCO rather than by the Provider, unless otherwise specified by the ODM [OAC 5160-26-05(A)(3)(h)].

137. To the extent that MCO is delegating to Provider any provider-credentialing/recredentialing activities or responsibilities in connection with the Three-Way Contract, the Two-Way Contract, and/or the Demonstration, MCO shall retain the authority to approve, suspend, or terminate any such providers. [OAC 5160-26-05(C)(5)]

138. Provider shall retain and safeguard all hard copy or electronic records originated or prepared in connection with the Three-Way Contract, the Two-Way Contract, and/or the Demonstration, including without limitation working papers or information related to the preparation of reports, medical records, progress notes, charges, journals, ledgers, and fiscal reports, all in accordance with applicable sections of the federal regulations, the Ohio Revised Code, and the Ohio Administrative Code. Records stored electronically must be produced at Provider's expense, upon request, in the format specified by state or federal authorities. All such records must be maintained for a minimum of eight years from the renewal, amendment, or termination date of the Agreement, or in the event that Provider has been notified that state or federal authorities have commenced an audit or investigation, until such time as the matter under audit or investigation has been resolved. For the initial three years of the eight-year retention period, Provider shall store the aforementioned records in a manner and place that provides readily available access. [OAC 5160-26-06(F)]

139. Provider shall not advise or recommend to any Beneficiary that he/she select membership in any particular Demonstration managed-care organization, including without limitation MCO. [OAC 5160-26-08(C)(1)]

140. With respect to MCO's coordination-of-benefits duty to pursue third-party resources that may be available for the payment of medical expenses for Covered Benefits:

a. If Provider receives payment from a third-party payor after MCO has made payment for the same Covered Benefits, Provider shall repay MCO for any amount that MCO has overpaid to Provider, and Provider shall not reimburse any overpaid amounts to the Beneficiary. [OAC 5160-26-09.1(C)(7)]

b. Provider shall not bill or hold a Beneficiary liable in the event that MCO cannot or will not pay for Covered Services unless all of the specifications set forth in OAC 5160-26-05 and OAC 5160-26-11 have been met. Furthermore, Provider shall not collect from and/or bill a Beneficiary for any difference between the MCO payment and Provider's charge, and shall not request that the Beneficiary share in the cost of the Covered Services through a deductible, coinsurance, co-payment, or other similar charge, other than MCO co-payments as permitted by law. [OAC 5160-26-09.1(C)(11)]

H. Medicare Requirements

Without limiting any obligation of Provider under the Agreement, Provider shall comply with, and shall cause its Downstream Entities and Related Entities to comply with, the requirements set forth in this **Section B** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider), as applicable, that relate to those Covered Services or to the Three-Way Contract and the Demonstration (the "Medicare Services"). (The terms "Downstream Entities" and "Related Entities" shall have the respective meanings that are ascribed to them in the Medicare Services Exhibit to the Agreement (the "Medicare Services Exhibit"), and shall include Provider's permanent and temporary employees.) For

purposes of this **Section B**, the Members dually eligible for both Medicare and Medicaid under the Three-Way Contract and the Demonstration shall collectively be referred to as the "Medicare Members," and the managed-care plan that MCO offers under the Three-Way Contract and the Demonstration shall be referred to as the "Medicare Plan." Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

14. PAYMENT.

E. 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 Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement).

F. MCO shall not pay any amounts beyond the amounts set forth in the applicable Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement), 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 MCO 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, MCO's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. MCO 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 adjust payments to Provider for Covered Services until the earlier of (i) the discontinuation of the Medicare Payment Adjustment, or (ii) the replacement of the Medicare Payment Adjustment by a subsequent Medicare Payment Adjustment.

G. Pursuant to Section B.5.K. of this Duals Addendum, Provider certifies that the diagnosis codes submitted to MCO for Medicare Members that MCO is required to submit to CMS will be accurate, complete, and truthful (the "Certification"). Provider acknowledges and agrees that MCO may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to MCO 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, "diagnosis code" shall mean an International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) code or its successor.

H. 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 (the "Medicare Statute of Limitations"). If MCO makes an overpayment or payment in error to Provider for Medicare Members, MCO 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 MCO's reasonable suspicion of fraud or other intentional misconduct.

I. In no event, including without limitation non-payment by MCO, insolvency of MCO, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Medicare Member or persons (other than MCO) acting on a Medicare Member's behalf for services covered under the Agreement. Provider further agrees that: (i) this provision shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Medicare Members, and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Medicare Member or

persons acting on a Medicare Member's behalf. No modification of this provision shall be effective without the prior written approval of the appropriate regulatory entities.

15. ASSIGNMENT. In addition to all other rights of MCO under the Agreement, the Agreement (including, but not limited to, as it relates to the line(s) of business described in this Duals Addendum) may be assigned by MCO, at any time and from time to time, in whole or in part, to any other affiliate or successor in interest of MCO. At MCO's option, the Agreement shall survive, without any other change in its terms, as a distinct, separate agreement with MCO for those products/lines of business designated by MCO 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, MCO shall provide advance written notice to Provider. In the event of a conflict between this Section and any other provision of the Agreement, the terms of this Section shall supersede and prevail.

16. EFFECT OF TERMINATION. In the event this Duals Addendum is terminated for any reason, such termination shall not constitute termination of any of MCO's other products, plans, or programs.

17. MEDICARE REQUIRED PROVISIONS. Provider agrees to comply with all of the provisions of the Schedules attached hereto and incorporated into this Duals Addendum (including the Medicare Services Exhibit and any delegated function-specific Schedules that may be appended hereto), and agrees that all terms and conditions in the Agreement applicable to Provider shall also apply to any Downstream Entities of Provider. Provider further acknowledges and agrees that all terms of such Schedules shall apply equally to services provided in connection with the Three-Way Contract and the Demonstration, even if such Schedules only refer to Medicare Advantage products. Provider acknowledges that to the extent MCO is delegating to Provider any activities and responsibilities in connection with the Three-Way Contract and the Demonstration, MCO may only delegate such activities and responsibilities in a manner consistent with the contractual and legal obligations and duties imposed on MCO under the Three-Way Contract and under applicable Medicare laws, regulations, rules, and other directions of CMS.

18. PROVIDER OBLIGATIONS.

GG. 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.

HH. Compliance; Cooperation. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement will be consistent and comply with MCO's obligations under the Three-Way Contract. Upon request, Provider shall immediately provide to MCO any information that is required by MCO 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 MCO that MCO, 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 MCO to process Medicare appeals and grievances in accordance with Medicare laws, regulations, and CMS instructions.

II. Federal Fund Obligations. Provider understands and agrees that payments received by MCO for the Medicare Plan from CMS pursuant to the Three-Way Contract, as well as payments that Provider receives from MCO for performing services and functions under the Agreement, constitutes the receipt of federal funds. As a result, Provider, by entering into this Agreement and the terms of this Duals 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.

JJ. Continuation of Services. In the event the Three-Way Contract terminates or MCO becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized 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 Duals Addendum, regardless of the reason for termination, including the insolvency of MCO, and shall supersede any oral or written agreement between Provider and a Medicare Member.

KK. Policies, Programs & Procedures. Provider agrees to comply with MCO's policies and procedures (which MCO shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Duals Addendum, and the Three-Way Contract and Demonstration. Provider agrees to comply with MCO's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies MCO may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that an MCO 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.

LL. Maintenance of Records. Provider, on behalf of itself and its Downstream Entities (if any), shall preserve records applicable to Medicare Members or to MCO's participation in the Three-Way Contract and Demonstration, 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 42 C.F.R. § 423.2480(c) and to maintain all records containing data used by MCO to calculate Medicare medical loss ratios ("MLRs") for MCO's Medicare products and/or evidence needed by MCO 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 MCO to CMS. Provider further agrees that with respect to Medicare Plans, MCO and federal governmental authorities having jurisdiction, and their designees, upon request, shall have access to all MLR Records, and that this right of inspection, evaluation, and audit of MLR Records shall continue for a minimum of ten (10) years from the date such MLRs were reported by MCO to CMS. This provision shall survive the termination of the Agreement, regardless of the cause of termination.

MM. 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 (a) all of the contractual and legal obligations and duties imposed on Provider in the Agreement, (b) all provisions required under Medicare laws, regulations, rules, and other directions of CMS (including all of MCO's obligations under such laws, regulations, rules, and other directions related to the scope of Provider's services under the Agreement), and (c) that any delegated services or activities to be performed by subcontractor shall be consistent and comply with the obligations in the Three-Way Contract. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly. Provider acknowledges that, with respect to any services or functions under the Agreement that Provider delegates to a subcontractor, such subcontractor shall be considered a Downstream Entity.

(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 MCO delegates to Provider the selection of providers, MCO retains the right to approve, suspend or terminate such delegation. If MCO delegates the selection of providers, MCO will either review the credentials of medical professionals affiliated with Provider or MCO 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.

NN. Contracts with Excluded Entities. Provider understands and agrees that no person that provides health care services and/or 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 shall not employ or contract with, with or without compensation, any individual or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in a federal health care program. 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. Furthermore, neither Provider nor any of Provider's Downstream Entities who are and/or will be fully or partially responsible for Provider's performance of its obligations under the Agreement has (i) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; (ii) been excluded from participation in any federal or state funded health program; or (iii) been listed in the Department of Health and Human Services Office of Inspector ("OIG") exclusion list or the General Services Administrative ("GSA") exclusion list. Provider agrees to immediately notify MCO in the event that Provider or any of its Downstream Entities that assist or are involved in Provider's performance of services for Medicare Plans under the Agreement are or become disbarred, excluded, suspended, or otherwise determined to be ineligible to participate in a federal health care program. 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, the "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 the Medicare Plan, 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 Duals Addendum, MCO shall have the right, in its sole discretion and judgment, to terminate this Duals 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.

OO. Offshore Services. Provider is prohibited from using any individual or entity (an "Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative, or other individual or entity) to perform any services for the Medicare Plan 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 MCO, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that MCO has the right to audit any Offshore Entity prior to the provision of Offshore Services for the Medicare Plan. Provider further represents and warrants that it does not and will not permit any Medicare Members' protected health information (PHI) or other personal information to be accessible by any Offshore

Entity, without prior written notice to MCO and MCO's prior written approval of such Offshore Entity. In the event that MCO agrees in advance and in writing to permit Provider to use an Offshore Entity to perform any services for Medicare Plans and MCO agrees that such Offshore Entity will receive, process, transfer, handle, store, or access Medicare Member PHI as defined at 45 C.F.R. § 160.103, Provider agrees that Offshore Services that involve Medicare Member 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.

PP. Submission of Encounter Data. Provider hereby acknowledges that MCO 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 MCO and to provide MCO with all such information in such form and manner as requested by MCO. Provider agrees to immediately notify MCO if any encounter data that Provider submitted to MCO for Medicare Members is inaccurate, incomplete, or erroneous, and to cooperate with MCO to correct erroneous encounter data to ensure MCO's compliance with Medicare laws, rules and regulations and CMS instructions.

QQ. Certification of Data. Provider recognizes that MCO 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 MCO by its contractors and subcontractors. Provider and its subcontractors, if any, hereby certify that any such data submitted to MCO will be accurate, complete, and truthful. Upon request, Provider shall make such certification in the form and manner prescribed by MCO.

RR. Medicare Member Complaints. Provider agrees to cooperate with MCO in resolving any Medicare Member complaints related to coverage or the provision of Covered Services. MCO 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 MCO in the required time. Provider shall use best efforts to resolve complaints in a fair and equitable manner.

SS. Compliance Program and Anti-Fraud Initiatives. Provider shall (and shall cause its Downstream Entities, if any, 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 the Medicare Plan. Such compliance program shall be appropriate to the organization and operations of Provider and Provider's Downstream Entities and shall include:

(11) written compliance policies and standards of conduct that are comparable to Aetna's compliance policies/Aetna Code of Conduct and articulate the entity's commitment to comply with federal and state laws, ethical behavior, and compliance program operations. Provider will disseminate either Aetna's compliance policies/Aetna Code of Conduct or comparable versions to Provider's employees, officers, and Downstream Entities within 90 days of hire/contracting, when updates are made, and annually thereafter;

(12) reporting mechanisms communicated to Provider's employees and Downstream Entities for their use in adhering to the expectation that Provider, its employees, and its Downstream Entities report potential non-compliance or FWA issues (internally and to MCO, as applicable) and understand their obligation to report. Provider must publicize the reporting methods to Provider employees and Downstream Entities along with a no-tolerance policy for retaliation or retribution for good-faith reporting;

(13) completion of CMS's Medicare Learning Network® (MLN) "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training" by Provider employees, officers, and Downstream Entities initially within ninety (90) days of hire/contracting and at least annually thereafter, unless exempt from such training under relevant CMS regulations;

(14) processes to oversee and ensure that Provider and Provider's Downstream Entities maintain compliance with processes to oversee and ensure that: (1) Provider and Provider's Downstream Entities maintain compliance with CMS compliance program requirements, and (2) Provider's Downstream Entities perform Medicare Services consistent with this Agreement and the agreement between Provider and such Downstream Entities. Provider's oversight under this Agreement shall include: (1) imposition of disciplinary actions, as needed, to ensure employee compliance with CMS compliance program requirements, and (2) implementation of corrective actions (up to and including contract termination), as needed, with respect to its Downstream Entities to ensure Downstream Entity compliance with applicable CMS requirements, including the CMS compliance program requirements, this Agreement, and Provider's contract with the Downstream Entity; and

(15) retention of evidence showing that Provider and Provider's Downstream Entities complied with the requirements set forth in this Section. Such evidence must be maintained for at least the period of time specified in Section B.5.F. hereof and shall be made available to MCO and CMS, upon request.

TT. Marketing. Consistent with federal laws, regulations, and agency requirements applicable to the Medicare program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare Members, 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.

UU. Dual-Eligible Hold Harmless. Provider acknowledges and agrees that Medicare 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 it will not collect Cost Sharing Amounts from Medicare Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the MCO'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.

VV. Enrollment as Medicare Provider. To the extent that Provider prescribes drugs covered under Medicare Part D to Medicare Members who have Medicare prescription drug ("MA-PD") coverage offered by MCO, Provider agrees to comply with the requirements set forth in 42 C.F.R. § 423.120(c)(6), including without limitation the requirement that Provider be enrolled in Medicare in an approved status in order for its prescriptions to be covered under Medicare Part D.

WW. Home Infusion Drugs. The following provisions shall only apply to Provider if Provider dispenses to a Medicare Member home infusion drugs that are covered under Medicare Part D and the Medicare Member has MA-PD coverage offered by MCO ("Home Infusion Drug"):

23. With respect to Home Infusion Drugs, MCO will pay clean claims (as defined in 42 C.F.R. § 423.520(b)) submitted by Provider on behalf of Medicare Members within 14 days for electronic claims and within 30 days for claims submitted otherwise. 42 C.F.R. § 423.505(i)(3)(vi).

24. Home Infusion Drugs will be reimbursed (as applicable) in accordance with a fee schedule, or the third-party pricing source (*e.g.*, Medi-Span) otherwise agreed upon as set forth in this Agreement or Provider's agreement with MCO's Pharmacy Benefit Manager ("PBM"). 42 C.F.R. § 423.505(i)(3)(viii)(B).

25. If a prescription drug pricing standard is used for reimbursement of Home Infusion Drugs, updates to such a standard will occur not less frequently than once every 7 days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the Home Infusion Drug. 42 CFR § 423.505(i)(3)(viii)(A).

26. In accordance 42 C.F.R.§ 423.120(c)(3), Provider agrees to submit claims for Home Infusion Drugs to MCO or its PBM whenever the Medicare Member's ID card is presented or is on file at the Provider, unless the Medicare Member expressly requests that the claim not be submitted to MCO or its PBM.

27. Provider must submit claims for Home Infusion Drugs in real time by means of point of service claims adjudication systems in compliance with CMS standards. 42 C.F.R. § 423.505(b)(17).

28. Provider must provide Medicare Members with access to the negotiated prices (as defined in 42 C.F.R. § 423.100) for Home Infusion Drugs to Members. 42 C.F.R. § 423.104(g)(1).

29. Provider must charge/apply the correct cost-sharing amount to the Medicare Member for Home Infusion Drugs. 42 C.F.R. § 423.104.

30. At the time of purchase by a Medicare Member, Provider must inform the Medicare Member of any differential between the price of the Home Infusion Drug being dispensed and the price of the lowest priced generic version of that Home Infusion Drug available from Provider, unless the Home Infusion Drug being dispensed is the lowest priced generic version of that Home Infusion Drug. 42 C.F.R. § 423.132.

31. Provider agrees to ensure that the professional services and ancillary supplies necessary for Home Infusion Drugs are in place before dispensing Home Infusion Drugs to a Medicare Member in his/her place of residence. 42 C.F.R. § 423.120(a)(4)(iii).

32. Provider agrees to provide delivery of Home Infusion Drugs within 24 hours of a Medicare Member's discharge from an acute setting, or later if so prescribed. 42 C.F.R. § 423.120(a)(4)(iv).

33. Provider shall submit to MCO (not PBM) claims for equipment, supplies, and professional services associated with Home Infusion Drugs dispensed by Provider to a Medicare Member that are covered under Medicare Part C.

XX. Non-Covered Services. Provider shall not hold a Member financially responsible for payment of a service not covered under the Member's Plan ("Non-Covered Service") unless the Member has received a pre-service organization determination notice of denial from MCO before such services are rendered. Provider acknowledges and agrees that if Provider renders Non-Covered Services to a Member who has not received a pre-service organization determination notice of denial from MCO, the Provider must hold the Member harmless for the Non-Covered Services and cannot charge the Member any amount beyond the normal cost-sharing amounts (*i.e.*, copayments, coinsurance, and/or deductibles). With respect to those Non-Covered Services that are clearly listed as exclusions in the Member's Evidence of Coverage or other similar Plan document, a pre-service organization determination is not required in order for Provider to hold the Member financially liable for such Non-Covered Services.

19. COMPANY OBLIGATIONS.

A. Fee Schedule. MCO shall arrange for Provider to be compensated for health care services

rendered to Medicare Members in accordance with Section B.1 of this Duals Addendum.

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(a)(1), MCO 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 Duals Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. § 422.500.

C. From time to time MCO may designate only certain Providers to take part in the provider delivery network for a particular product benefit plan(s).

20. GENERAL PROVISIONS.

A. Termination. This Duals 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 and the Three-Way Contract. This Duals Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement and the Three-Way Contract.

B. Governing Law. This Duals Addendum shall be governed by federal laws, regulations, and agency requirements applicable to the Medicare program. In the event that changes to the governing laws, regulations, or agency requirements applicable to the Medicare program occur, the new law, regulation, or agency requirement shall supersede to the extent required by any such later required changes.

C. Agreement Otherwise Unmodified. 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 Duals Addendum and the Agreement, the terms of this Duals Addendum shall govern and control.

D. Survival. All provisions of this Duals Addendum that 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.

I. Requirements Under the Demonstration's Three-Way Contract and Two-Way Contract

The Three-Way Contract and Two-Way Contract require that specific additional terms and conditions be incorporated into the Agreement. As such, Provider shall comply with, and shall cause its downstream entities and related entities to comply with, the requirements set forth in this **Section C** with respect to the provision of Covered Services to Members dually eligible for both Medicare and Medicaid under the Three-Way Contract, the Two-Way Contract, and the Demonstration, and with respect to the provision of administrative or health-benefit management services/functions (or other functions delegated to Provider) that relate to those Covered Services or to the Three-Way Contract, the Two-Way Contract, and the Demonstration. With respect to the requirements set forth in this **Section C**, any capitalized terms that are used but not defined herein shall have the meanings that are ascribed to them in the Three-Way Contract or the Two-Way Contract, as applicable. Provider's obligations specifically include, and Provider expressly agrees to comply with, the following:

1. The delegated activities and reporting requirements for which Provider is responsible are contained in the Agreement. Provider shall ensure that it and its downstream and related entities perform all such delegated activities and reporting requirements in compliance with 42 C.F.R. §§ 422.504, 423.505, 438.6(l), and 438.230(b)(1), as applicable. [Appendix C, ¶ A of Three-Way Contract]

2. HHS, the Comptroller General, the Department, and their respective designees have the right to

audit, evaluate, and inspect any books, contracts, computer, or other electronic systems, including medical records and documentation, of Provider and its downstream and related entities, and the foregoing rights to inspect, evaluate, and audit any pertinent information for any particular contract period shall exist for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later. [Appendix C, ¶ C of Three-Way Contract]

3. Provider and its downstream and related entities shall not hold Beneficiaries liable for payment of any fees that are the obligation of MCO. [Appendix C, ¶ D.1 of Three-Way Contract]

4. Any services or other activity performed by Provider and/or its downstream and related entities shall be performed in accordance with the MCO's contractual obligations to CMS and the Department. [Appendix C, ¶ D.2 of Three-Way Contract]

5. MCO shall revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS, the Department, or the MCO determine that Provider and/or its downstream and related entities have not performed their delegated activities or reporting requirements satisfactorily. [Appendix C, ¶ D.4 of Three-Way Contract]

6. The performance of Provider and its downstream and related entities under the Agreement will be monitored by MCO on an ongoing basis and MCO may impose corrective action as necessary. [Appendix C, ¶ D.5 of Three-Way Contract]

7. Provider and its downstream and related entities agree to safeguard Beneficiary privacy and confidentiality of Beneficiary health records. [Appendix C, ¶ D.6 of Three-Way Contract]

8. Provider and its downstream and related entities must comply with all federal and state laws, regulations, and CMS instructions. [Appendix C, ¶ D.7 of Three-Way Contract]

9. To the extent that Provider and/or its downstream and related entities provide credentialing of medical providers under the Agreement:

   A. The credentials of medical professionals affiliated with the Provider and/or its downstream and related entities will be reviewed by MCO; or

   B. The credentialing process will be reviewed and approved by MCO and MCO shall audit the credentialing process on an ongoing basis.

   [Appendix C, ¶ E of Three-Way Contract]

10. To the extent that MCO has delegated the selection of providers under the Agreement to Provider or its downstream and related entities, MCO retains the right to approve, suspend, or terminate that arrangement. [Appendix C, ¶ F of Three-Way Contract]

11. MCO shall provide a written statement to Provider of the reason or reasons for termination for cause. [Appendix C, ¶ G of Three-Way Contract]

12. MCO is obligated to pay Provider under the terms of the Agreement, which includes a prompt-payment provision that has been developed and agreed to by both MCO and Provider. [Appendix C,

¶ H.1 of Three-Way Contract]

13. Provider and its downstream and related entities shall provide all services under the Agreement in a Culturally Competent manner to all Beneficiaries, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds. [Appendix C, ¶ H.2 of Three-Way Contract]

14. Provider and its downstream and related entities shall abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information. [Appendix C, ¶ H.3 of Three-Way Contract]

15. Provider and its downstream and related entities shall ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas. [Appendix C, ¶ H.4 of Three-Way Contract]

16. Provider and its downstream and related entities shall maintain Beneficiary records and information in an accurate and timely manner. [Appendix C, ¶ H.5 of Three-Way Contract]

17. Provider and its downstream and related entities shall ensure timely access by Beneficiaries to the records and information that pertain to them. [Appendix C, ¶ H.6 of Three-Way Contract]

18. Provider and its downstream and related entities shall not hold Beneficiaries liable for Medicare Part A and B cost sharing, and all Medicare Parts A and B services must be provided at zero cost-sharing to Beneficiaries. [Appendix C, ¶ H.7 of Three-Way Contract]

19. Provider and its downstream and related entities shall ensure that their EMTALA obligations are fulfilled as required by law and the Agreement and must not create any conflicts with any hospital actions required to comply with EMTALA. [Appendix C, ¶ H.8 of Three-Way Contract]

20. Provider and its downstream and related entities, including without limitation all primary care providers, shall not close or otherwise limit acceptance of Beneficiaries as patients unless the same limitations apply to all commercially insured Beneficiaries. [Appendix C, ¶ H.9 of Three-Way Contract]

21. MCO shall not refuse to contract or pay Provider for the provision of Covered Services solely because Provider has in good faith:

    (a) Communicated with or advocated on behalf of one or more of the prospective, current, or former patients of Provider or its downstream and related entities regarding the provisions, terms, or requirements of the MCO's health benefit plans as they relate to the needs of such patients; or

    (b) Communicated with one or more of the prospective, current, or former patients of Provider or its downstream and related entities with respect to the method by which such provider is compensated by the MCO for services provided to the patient.

[Appendix C, ¶ H.10 of Three-Way Contract]

22. Provider and its downstream and related entities are not required to indemnify MCO for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against MCO based on MCO's management decisions, utilization review provisions, or other policies, guidelines, or actions. [Appendix C, ¶ H.11 of Three-Way Contract]

23. Provider and its downstream and related entities shall comply with all MCO's requirements and MCO Policies for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services. [Appendix C, ¶ H.12 of Three-Way Contract]

24. MCO shall notify Provider in writing of modifications in payments, modifications in Covered Services or modifications in MCO's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 30 calendar days before the effective date of such modification unless such other date for notice is mutually agreed upon between MCO and Provider or unless such change is mandated by CMS or the Department without 30 calendar days' prior notice. [Appendix C, ¶ H.13 of Three-Way Contract]

25. Provider must comply with all Beneficiary payment restrictions, including balance billing restrictions, and MCO may revoke or impose other specified remedies against Provider if Provider does not comply with such provisions. [Appendix C, ¶ H.14 of Three-Way Contract; Appendix C, Section 60 of Two-Way Contract]

26. Provider and its downstream and related entities shall not bill Beneficiaries for charges for Covered Services other than pharmacy co-payments, if applicable. [Appendix C, ¶ H.15 of Three-Way Contract; Appendix C, Section 60 of Two-Way Contract]

27. No payment shall be made by MCO to Provider, and Provider shall not seek payment from MCO, for a Provider Preventable Condition as defined in 42 C.F.R. § 447.26(b), and Provider shall, as a condition of payment from MCO, comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by MCO and/or the Department. [Section 2.7.6.2 and Appendix C, ¶ H.16 of Three-Way Contract]

28. Provider shall ensure coverage for its practice twenty-four (24) hours a day, seven (7) days a week, when medically necessary. [Section 2.8.5.3 of Three-Way Contract; Appendix H, Section 1 of Two-Way Contract]

29. MCO shall monitor and ensure that all utilization management activities provided by Provider comply with all provisions of the Three-Way Contract with CMS and the Department, and Provider and its downstream and related entities shall cooperate with and utilize MCO's quality assurance program. [Section 2.11.2.2.3.2 of Three-Way Contract]

30. Provider shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. Contracts or arrangements with First Tier, Downstream and Related Entities shall not include incentive plans that include a specific payment to Provider or its downstream and related entities as an inducement to deny, reduce, delay, or limit specific, Medically Necessary Services, and (a) Provider and/or its downstream and related entities shall not profit from provision of Covered Services that

are not Medically Necessary or medically appropriate, and (b) MCO shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate. [Appendix C, ¶¶ H.14 and I, and Section 5.1.7.2 of Three-Way Contract]

31. MCO shall not impose a financial risk on Provider or its downstream and related entities for the costs of medical care, services, or equipment provided or authorized by another Physician or health care provider unless such contract includes specific provisions with respect to the following:

E. Stop-loss protection;

F. Minimum patient population size for the Physician or Physician group; and

C. Identification of the health care services for which the Physician or Physician group is at risk.

[Appendix C, ¶ J of Three-Way Contract]

32. All contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites that provide services must include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. [Appendix C, ¶ K of Three-Way Contract]

33. Nothing shall be construed to restrict or limit the rights of MCO to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious nonmedical providers. [Appendix C, ¶ L of Three-Way Contract]

34. Provider shall meet all terms and requirements of the Three-Way Contract that are applicable to Provider. [Section 2.7.3.1 of Three-Way Contract]

35. Provider and its downstream and related entities shall allow MCO to access the medical records of Beneficiaries. [Section 2.7.7.1.4 of Three-Way Contract]

36. Provider will collaborate with MCO on documentation systems reporting, communications, policies, and any other matters necessary for any readiness review required under the Three-Way Contract. [Section 2.2.1.of Three-Way Contract]

37. Provider shall collaborate with MCO, as requested and required under the Three-Way Contract, on activities relating to Care Management, the Individualized Care Plan, the Centralized Enrollee Record, and the Care Management System. [Section 2.5.3 of Three-Way Contract]

38. As requested and required under the Three-Way Contract, Provider shall actively participate as a member of the Trans-Disciplinary Care Team, and shall collaborate with the Beneficiary and other members of the Trans-Disciplinary Care Team to perform the functions and tasks that are required of the Trans-Disciplinary Care Team under the Three-Way Contract. [Section 2.5.3 of Three-Way Contract]

39. Provider must comply with the United States Supreme Court's *Olmstead* decision, which requires that Beneficiaries be served in the most integrated setting appropriate to their needs. [Section 2.5.3.4.1.1

of Three-Way Contract]

40. Provider shall be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender, and other unique needs of any minority, homeless population, Beneficiary with disabilities (both congenital and acquired disabilities), or other special population served by the MCO. [Section 2.6.1.10 of Three-Way Contract]

41. To the extent that Provider is multilingual, Provider shall understand and comply with its obligations under state or federal law to assist Beneficiaries with skilled medical interpreters and the resources that are available to assist Provider to meet these obligations. [Section 2.6.1.12 of Three-Way Contract]

42. Provider shall comply with timely access requirements pursuant to 42 C.F.R. § 438.206(c)(1). [Section 2.7.4 of Three-Way Contract]

43. Provider must be appropriately licensed or certified, as applicable, if required pursuant to federal and state requirements. [Section 2.7.3.4 of Three-Way Contract]

44. Provider shall notify MCO immediately if Provider has lost any required license or state or federal approval, or been excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. [Section 5.1.5.1 and 5.3.4 of Three-Way Contract]

45. Provider shall not engage in any practice with respect to any Beneficiary that constitutes unlawful discrimination under any state or federal law or regulation. [Section 2.3.1.2 of Three-Way Contract]

46. As requested by MCO, Provider shall submit disclosures in accordance with 42 C.F.R. § 455 Subpart B and 42 C.F.R. § 1002.3. [Section 5.1.6.1 of Three-Way Contract]

47. Providers shall offer hours of operation to Beneficiaries that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service (if the Provider serves only Medicaid beneficiaries). [Section 2.8.5.3 of Three-Way Contract; Appendix H, Section 1 of Two-Way Contract]

48. Provider must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) as outlined in the Three-Way Contract, and must maintain capacity to deliver services in a manner that accommodates the needs of Beneficiaries. [Section 2.8.1.3 of Three-Way Contract]

49. Upon MCO's request, Providers must provide the following information: (a) its name, address, and telephone number; (b) its areas of special experience, skills, and training, including any expertise in treating persons with physical disabilities, chronic illness, HIV/AIDS, or persons with serious mental illness; persons who are homeless; persons who are deaf, hard-of-hearing, blind, and/or visually impaired; or persons with co-occurring disorders; (c) its office hours, including the name of any Provider site open after 5:00 p.m. (Eastern Time) on weekdays and/or open on weekends; (d) whether the Provider has completed cultural competence training; (e) its licensing information, such as license number or National Provider Identifier; (f) whether it has specific accommodations for people with physical disabilities; (g) whether it is accepting new patients; (h) whether it is on a public

transportation route; (h) any languages other than English, including ASL, spoken by Provider or offered by skilled medical interpreters at Provider's site, and whether it has access to language line interpreters; and (i) for any behavioral-health Provider, whether it has training in and experience treating trauma, child welfare, and substance use. [Section 2.12.5.2 of Three-Way Contract]

50. As requested and required, Provider must provide any information that CMS and/or the Department require (a) under the Three-Way Contract related to the performance of MCO's responsibilities, including non-medical information for the purposes of research and evaluation; (b) to comply with all applicable federal or state laws and regulations; and (c) for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Beneficiary satisfaction, Beneficiary Grievances and Appeals, and enrollment/disenrollment rates. [Section 2.14.1.1 of Three-Way Contract]

51. Provider shall collaborate with MCO in the collection and maintenance of all Encounter Data for all Covered Services that Provider provides to Beneficiaries, and ensure that all such data can be linked to the Department eligibility data according to the specifications, format, and mode of transfer established by CMS and/or the State. As directed by CMS and/or the State, such Encounter Data shall include the National Provider Identifier (NPI) of the billing professional and any National Drug Code (NDC), and if available, information on ordering and referring physician must be included. [Section 2.15 of Three-Way Contract]

52. In connection with the Demonstration, Provider shall act in an independent capacity and not as an officer or employee of the federal government or the Department. [Section 5.1.3.1 of Three-Way Contract]

53. Provider shall not have any interest that will conflict, as determined by CMS and the Department, with the performance of MCO's services under the Three-Way Contract, or that may be otherwise anticompetitive, including without limitation any financial, legal, contractual, or other business interest in any entity performing enrollment functions for the Department. [Section 5.3.17.1 of Three-Way Contract]

54. Provider shall conduct all activities in accordance with the Beneficiary rights and protections set forth under 42 C.F.R. § 438.100, 42 C.F.R. § 422 Subpart C, and Appendix B ("Beneficiary Rights") of the Three-Way Contract, and shall otherwise comply with all applicable federal and state laws that pertain to member rights and shall ensure that its staff adhere to such laws when furnishing services to Beneficiaries. [Appendix B of Three-Way Contract; Appendix C, Section 21 of Two-Way Contract; OAC 5160-26-08.3]

55. Provider may not reuse or provide other entities access to the CMS information system, or data obtained from the system or the State of Ohio, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the MCO contracted with CMS and the Department. [Appendix E of Three-Way Contract]

56. If the Provider is discharging an Beneficiary from a hospital, Provider must comply with the requirements set forth in 42 C.F.R. §§ 422.620–422.622. [Section 2.10.4.1 of Three-Way Contract]

57. Provider shall not use any information, systems, or records that have been made available to it under the Three-Way Contract, the Two-Way Contract, and/or the Demonstration for any purpose other

than to fulfill the duties specified thereunder and under the Agreement. Provider agrees to be bound by the same standards of confidentiality that apply to the employees of the ODM and the State of Ohio, including without limitation the confidentiality requirements found in 42 C.F.R. Part 431 Subpart F and ORC 5160.45, as well as 42 C.F.R. § 2.12 and ORC 5119.27, as applicable. Provider must also implement procedures to ensure that in the process of coordinating care, each Beneficiary's privacy is protected consistent with the confidentialilty requirements of 45 C.F.R. Parts 160 and 164. [Article VIII, Section C of Two-Way Contract]

58. Provider shall indemnify and hold ODM and the State of Ohio harmless and immune from any and all claims for injury or damages resulting from the actions or omissions of Provider in the fulfillment of the Agreement, or arising from the Agreement that are attributable to Provider's own actions or omissions, or those of its trustees, officers, employees, agents, subcontractors, suppliers, third parties used by Provider, or joint venturers. Such claims shall include but are not limited to: any claims made under the Fair Labor Standards Act or under any other federal or state law involving wages, overtime, or employment matters and any claims involving patents, copyrights, trademarks, and applicable public-records laws. [Article X, Section A of Two-Way Contract]

59. Provider shall comply with all applicable state and federal laws regarding a smoke-free and drug-free workplace, and shall not purchase, transfer, use, or possess illegal drugs or alcohol, or abuse prescription drugs, in any way while performing duties under the Agreement. [Article XII, Section I of Two-Way Contract]

60. Unless otherwise requested by the ODM and/or the State of Ohio, Provider shall not communicate directly with the ODM or the State of Ohio regarding the Agreement or the Provider's services under the Three-Way Contract, the Two-Way Contract, and/or the Demonstration, unless the MCO is also participating in that discussion and the discussion is with the specific Contract Administrator assigned to the MCO. [Appendix C, Section 4.c. of Two-Way Contract]

61. If Provider or its employees have in-person contact with Beneficiaries in the Beneficiaries' homes, Provider shall comply with all criminal record check requirements as specified by the ODM. [Appendix C, Section 11 of Two-Way Contract]

62. In compliance with 45 C.F.R. Part 164, Provider shall ensure that if it creates, receives, maintains, or transmits Beneficiary protected health information (PHI) from or on behalf of the MCO and/or the ODM, it will abide by the same restrictions, conditions, and requirements that apply to the MCO with respect to the use or disclosure of such Beneficiary protected health information (PHI). [Appendix C, Section 30.f. of Two-Way Contract]

63. Notwithstanding anything to the contrary in Section B.5.I. of this Duals Addendum, Provider shall comply with Ohio Executive Order 2011-12K (available at http://governor.ohio.gov/MediaRoom/ExecutiveOrders.aspx). This Executive Order prohibits the use of public funds to purchase services that will be provided outside of the United States except under certain circumstances. Such services include the use of offshore programming or call centers. In addition, Provider shall not transfer Beneficiary protected health information (PHI) to any location outside the United States or its territories. [Appendix C, Section 61 of Two-Way Contract]

64. Provider shall cooperate with MCO with respect to MCO's obligations under the Three-Way

Contract, the Two-Way Contract, and/or the Demonstration, including without limitation:

i. MCO's obligation to abide by ODM's "Incident Management System" set forth in OAC 5160-58-05.3. [Section 2.5.3.3.5.4.4 of Three-Way Contract; OAC 5160-58-05.3]

ii. MCO's obligation to investigate and report fraud, waste, and abuse, with Provider reporting to MCO any suspected fraud, waste, or abuse of which Provider becomes aware. [Section 2.1.6 of Three-Way Contract; Appendix I, Section 1 of Two-Way Contract; OAC 5160-26-06]

iii. MCO's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [Sections 5.1.4 & 5.1.13 of Three-Way Contract; Appendix C, Section 53 of Two-Way Contract; OAC 5160-26-09.1]

iv. MCO's obligation to respond to any deficiency/non-performance notice, breach/default notice, or request for a corrective action plan that MCO receives from ODM or the State of Ohio relating to Provider or to the services that are within the scope of the Agreement. [Section 5.3.13 of Three-Way Contract; Appendix N of Two-Way Contract; OAC 5160-26-10]

v. MCO's obligation to submit financial and expense-related reports/data to ODM and/or the State of Ohio relating to risk-adjustment and Medical Loss Ratio (MLR) calculations set forth in the Three-Way Contract. [Section 4 of Three-Way Contract]

vi. MCO's obligation to submit reports and other data to ODM and/or CMS as set forth in the Three-Way Contract and Two-Way Contract, including HEDIS, CAHPS, and HOS data, and all other data that are required to satisfy MCO's reporting obligations to ODM and CMS. [Sections 2.11.3.4.1.6 & 2.14.2 of Three-Way Contract; Appendix M of Two-Way Contract]

vii. MCO's obligation to provide timely, substantive responses to information requests received from ODM and/or CMS in connection with the Three-Way Contract, the Two-Way Contract, and/or the Demonstration. [Section 2.2.2.1.7 of Three-Way Contract]

65. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, if MCO delegates to Provider any pharmacy-related activities or obligations that MCO has under the Three-Way Contract, Provider shall comply with all pharmacy-related provisions and requirements set forth in the Three-Way Contract, including without limitation the following, as applicable:

(a) Provider shall ensure that all non-Part D covered outpatient drugs dispensed to Beneficiaries shall be subject to the same rebate requirements as the State is subject to under section 1927 of the Social Security Act and that the State shall collect such rebates from pharmaceutical manufacturers. [Section 5.1.13.4.1 of Three-Way Contract]

(b) Provider shall cooperate with MCO with respect to MCO's obligation under the Three-Way Contract to submit to the State, on a timely and periodic basis, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Beneficiaries for

which MCO is responsible for coverage, and other data as specified by the State. [Section 5.1.13.4.2 of Three-Way Contract]

Exhibit C

Aetna Health Plans

Affiliate Name	Address	City	State	Zip
Aetna Better Health of Nevada.	475 E Capovilla Ave, Suite 100	Las Vegas	Nevada	89119
Aetna Better Health of California Inc.	2850 Shadelands Drive	Walnut Creek	California	94598
Coventry Health Care of Florida, Inc.	1340 Concord Terrace	Sunrise	Florida	33323
Aetna Better Health Inc. dba Aetna Better Health of Illinois	333 West Wacker Drive, Suite 2100	Chicago	Illinois	60606
Aetna Better Health of Kentucky Insurance Company	9900 Corporate Campus Drive, Suite 1000	Louisville	Kentucky	40223
Aetna Health Inc. dba Aetna Better Health of Louisiana	2400 Veterans Memorial Blvd., Suite 200	Kenner	Louisiana	70062
Aetna Better Health of Michigan Inc.	1333 Gratiot Ave, Suite 400	Detroit	Michigan	48207
Aetna Better Health Inc. dba Aetna Better Health of New Jersey	3 Independence Way, Suite 400	Princeton	New Jersey	08540
Aetna Better Health Inc. dba Aetna Better Health of Ohio	7400 West Campus Road	New Albany	Ohio	43054
Aetna Better Health Inc. dba Aetna Better Health of Pennsylvania	2000 Market St., Suite 850	Philadelphia	Pennsylvania	19103
Aetna Health Inc. dba Aetna Better Health Kids	2000 Market St., Suite 850	Philadelphia	Pennsylvania	19103
Aetna Better Health of Texas Inc.	2777 Stemmons Freeway Suite 300	Dallas	Texas	75207

Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia	9881 Mayland Dr.	Richmond	Virginia	23233
Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia	500 Virginia Street E, Suite 400	Charleston	West Virginia	25301

Signature: Marc Marini (Jul 17, 2017)

Email: marinim@aetna.com

AMENDMENT NO. 001 ("Amendment")
TO
SCHEDULE NO. 012 ("Schedule")
to the
PROFESSIONAL SERVICES AGREEMENT ("PSA")
between
AETNA LIFE INSURANCE COMPANY ("AETNA")
and
COTIVITI ("SUPPLIER")

This amendment ("Amendment") to Schedule No. 012 to the Professional Services Agreement dated July 10, 2000 between Cotiviti, LLC ("Supplier") and Aetna Life Insurance Company ("Aetna") ("Agreement") is made on January 1, 2019. The following amendments are incorporated into and made a part of the Agreement. All sections and paragraphs of the Agreement not hereby amended shall remain in full force and effect. Capitalized terms not otherwise herein defined shall have the meanings ascribed to them in the Agreement. In the case of a conflict, the terms of this Amendment will control and prevail over those contained in the Agreement. The Agreement shall remain in full force and effect, and except as hereby amended, is ratified and confirmed.

WHEREAS, the Parties wish to amend certain provisions applicable to the Services, add three Medicaid Plans (Kansas, Maryland and New York) and add Regulatory Compliance Addenda applicable to Kansas, California and Maryland;

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties agree to amend Schedule No. 012 to the Professional Services Agreement as follows:

1. Exhibit B of the Schedule is modified by adding following line items and Compliance Addenda:

   14. Exhibit B-14 Regulatory Compliance Addendum Governing Kansas Medicaid (Aetna Better Health of Kansas)
   15. Exhibit B-15 California Medicaid Compliance Addendum (Aetna Better Health of California)
   16. Exhibit B-16 Maryland Medicaid Compliance Addendum (Aetna Better Health of Maryland)

2. Section 4.A. ***Assignment Location,*** is hereby deleted and replaced with the following:

   A. Assignment Location (Where Services will be delivered):
   - 50 Danbury Road, Wilton, CT 06897
   - 785 Arbor Way, Suite 300, Blue Bell, PA 19422
   - 462 South Fourth Street, Louisville, KY 40202

3. The Schedule is hereby revised to add the following subsections:

   14 Aetna Training Course Completion by Aetna due date
   Supplier agrees that it will cause its personnel who are assigned log-on IDs to the Aetna claims system for purposes of performing audits to complete an annual training course supplied by Aetna. Aetna agrees to provide advance written notice that the training course is available and ready to be completed. If Supplier personnel with log on IDs to Aetna's systems do not complete the Aetna training courses by the due date assigned by Aetna in the applicable email communication, the Supplier will be placed on a corrective action plan to complete the training course. Supplier will make a good faith effort to complete the training course in accordance with Aetna's time frame, however, Supplier will be allowed at least a month to complete the training course before a corrective action plan is put in place. If the Supplier fails to complete the corrective action plan, a credit equal to $1,000 for each week the correction plan remains incomplete will be assessed.

   15 Privacy Inappropriate Disclosures
   Any improper disclosure of personally identifiable information (an "Improper Disclosure") in excess of one per calendar quarter will result in a performance credit being assessed upon Supplier in the amount of $1000 per

Improper Disclosure. If the Improper Disclosure is determined to have resulted from Supplier's failure obtain an affidavit of destruction, a performance credit of $5,000 for each such incident will be assessed. In the event that Supplier is responsible for more than two (2) Improper Disclosure per calendar quarter, a written corrective action plan will be imposed upon Supplier. Supplier's agrees that its failure to complete a corrective action plan and/or ongoing Improper Disclosures while a corrective action plan is in place will be considered a material breach of the Agreement. For the avoidance of doubt, nothing in this section shall be interpreted as excusing or permitting an Improper Disclosure or otherwise waiving or limiting Aetna's rights to pursue any and all other rights and remedies that may be available to it under this Agreement, including but not limited to the business associate agreement between the Parties, in law, in equity, or otherwise. At Aetna's election, performance credits assessed pursuant to this section will be realized as either a credit on the subsequent invoice or remitted to Aetna via check or another methodology agreed by the Parties.

The above paragraph notwithstanding, an Improper Disclosure for purposes of this Section is one personally identifiable information disclosure that result from a common cause regardless of the number of members affected in a single incident or disclosure. It will not be considered Supplier's responsibility, or an Improper Disclosure under this contract subject to credit unless Supplier was at fault for the Improper Disclosure, including scenarios where Supplier relied on information provided by Aetna and such reliance led to the disclosure (e.g., Aetna supplies an inaccurate provider address), if the mail delivery service made an error or if a lockbox error was made by a banking institution.

4. Exhibit C of the Schedule is modified by adding following table:

Affiliate Name	Address	City	State	Zip
Aetna Better Health of Kansas	9401 Indian Creek Parkway, Suite 1300	Overland Park	KS	66210
Aetna Better Health of Maryland	509 Progress Drive	Linthicum	MD	21090
Aetna Better Health of New York	55 West 125th Street, Suite 1300	New York	NY	10027

IN WITNESS WHEREOF, the Parties have hereto by their duly authorized representatives executed this Amendment.

AETNA LIFE INSURANCE COMPANY

Collin Bailey (Jan 31, 2019)
Authorized Signature

Collin Bailey
Print Name

Sr. Director
Title

Jan 31, 2019
Date

COTIVITI

David Mason (Jan 31, 2019)
Authorized Signature

David Mason
Print Name

COO
Title

Jan 31, 2019
Date

Exhibit B-14

Regulatory Compliance Addendum Governing Kansas Medicaid

Aetna Better Health of Kansas Inc. ("Company" or "MCO") has contracted with the Kansas Department of Health and Environment ("KDHE-DHCF" or "State Agency" or "Government Sponsor") to provide Medicaid managed care services to Members as part of the KanCare program ("KanCare"). The provisions of this Addendum are required by the State Contract, state or federal law for all Providers and/or Subcontractors. While every attempt is made to include all requirements herein, the State Contract shall control and this Addendum should not be considered exhaustive of all State Contract requirements. [State Contract § 1.21]

For purposes of this Addendum, "Provider" means the health care provider, group, facility, hospital, delegated entity, including any supplier, vendor, subcontractor, individual or entity contracted with Company (as identified on the first page of the Agreement) and engaged in the delivery of Covered Services, or ordering or referring for those Covered Services, and is legally authorized to do so by the State in which it delivers the Covered Services under the State Contract. For purposes of this Addendum, "Subcontractor" means the individual or entity with a Subcontract with Company (as identified on the first page of the Agreement) that relates directly or indirectly to the performance of the Company's obligations under the State Contract. For purposes of this Addendum, "Subcontract" means the written Agreement between the Company and Subcontractor. Capitalized terms used and not otherwise defined in this Addendum shall have the meanings set forth in the Agreement or, if not defined in the Agreement, as defined in the State Contract or under Kansas law. Pertinent information regarding the KanCare program, RFP and contracts with MCOs can be found on the Medicaid page of the KDHE website at: http://www.kancare.ks.gov/ or Company's State Contract.

If there is any conflict between the terms of this Addendum and any terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, if there is any conflict or ambiguity between any of the terms of the Agreement, including this Addendum and the State Contract, then the terms of the State Contract shall govern and control. If any requirement in the Agreement or this Addendum is determined by KDHE to conflict with the State Contract, such requirement shall be null and void, and all other provisions shall remain in full force and effect.

Each provision contained herein shall apply to Provider and/or Subcontractor only to the extent applicable to the services rendered by Provider and/or Subcontractor pursuant to the Agreement.

1. Subcontractor shall warrant that all persons it assigns to the performance of the Agreement shall be employees of Subcontractor and shall be fully qualified to perform the work required. Failure of Subcontractor to provide qualified staffing at the level required by the State Contract specifications may result in termination of the Agreement or damages. [See §1.20]

2. All terms, conditions and requirements of the State Contract shall apply without qualification to any services performed or goods provided under the Agreement. [See §1.21]

3. Subcontractor, and all lower tiered subcontractors under Subcontractor, shall properly classify workers as employees rather than independent contractors and treat them accordingly for purposes of workers' compensation insurance coverage, unemployment taxes, social security taxes, and income tax withholding. Failure to do so may result in termination of the Agreement. [See §1.23]

4. Subcontractor shall comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by Company, Subcontractor as well as any subcontractor or sub-contractors. The usual method of verification is through the Employment Verification (I-9) form. Subcontractor hereby certifies without exception that it has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the Agreement to termination for cause and any applicable damages. Unless provided otherwise herein, all Subcontractors and contractors are expected to be able to produce for

Company or the State any documentation or other such evidence to verify Subcontractor's IRCA compliance with any provision, duty, certification, or like item under the State Contract. [See §1.24 and Appendix B, #4]

5. If, during the term of the Agreement, Subcontractor plans to move work previously performed in the United States to a location outside of the United States, Subcontractor shall immediately notify Company who will notify KDHE in writing, indicating the desired new location, the nature of the work to be moved and the percentage of work that would be relocated. The State of Kansas, Director of Purchases, with the advice of the respective agency, must approve any changes prior to work being relocated. Failure to obtain Company's and the Director's approval may be grounds to terminate the Agreement for cause. [See §1.34]

6. Subcontracts shall (a) comply with the Kansas Act Against Discrimination (K.S.A. 44-1001 et seq.) and the Kansas Age Discrimination in Employment Act (K.S.A. 44-1111 et seq.) and the applicable provisions of the Americans With Disabilities Act (42 U.S.C. 12101 et seq.) (ADA) and to not discriminate against any person because of race, religion, color, sex, disability, national origin or ancestry, or age in the admission or access to, or treatment or employment in, its programs or activities; (b) to include in all solicitations or advertisements for employees, the phrase ""equal opportunity employer"; (c) to comply with the reporting requirements set out at K.S.A. 44-1031 and K.S.A. 44-1116; (d) to include those provisions in every subcontract or purchase order so that they are binding upon such subcontractor or vendor; (e) that a failure to comply with the reporting requirements of (c) above or if Company or Subcontractor is found guilty of any violation of such acts by the Kansas Human Rights Commission, such violation shall constitute a breach of the Agreement and/or State Contract, and the Agreement may be cancelled, terminated or suspended, in whole or in part, by Company, the contracting state agency or the Kansas Department of Administration; (f) if it is determined that Subcontractor has violated applicable provisions of ADA, such violation shall constitute a breach of the Agreement and the Agreement may be cancelled, terminated or suspended, in whole or in part, by Company, the contracting state agency or the Kansas Department of Administration. Subcontractor agrees to comply with all applicable state and federal anti-discrimination laws. [See §1.5 of DA-146a]

7. Subcontractor and any of its subcontractors shall certify to Company and the State, in accordance with section 1932(d)(1) of the SSA 42 CFR § 438.610, that they do not have any prohibited affiliations. [See §5.1.4.A.2]

8. Subcontractor shall provide its Business Continuity/Disaster Recovery Plan and Security Management Plan to Company for state approval as defined and detailed in the State Contract. [See §5.1.4.1 & 5.1.4.2]

9. Each employee, including the employees of Subcontractor or any other person to whom Company or Subcontractor grants access to information under the State Contract, shall sign a statement indicating he or she has been informed of, understands, and will abide by State and Federal laws, rules, statutes, guidelines, and regulations concerning confidentiality, privacy, and security. A system of sanctions for any employee, Subcontractor, officer, or director who violates the privacy and security policies shall be enforced. [See §5.1.4.2.C.15]

10. Subcontractor shall submit the approved User Security Agreement (initial and annually) required of all of their subcontractors who will come into contact with any secure information or data. [See §5.1.4.2.C.16]

11. Subcontractor shall have procedures and processes for securing data access across organizational boundaries, through the internet and other leased lines, or shared with and between Company and Subcontractor facilities, and all onsite and offsite data storage facilities. [See §5.1.4.2.C.20]

12. Subcontractor shall engage a third party, of the State's choosing, to conduct thorough system penetration testing. Subcontractor will develop a Corrective Action Plan for all vulnerabilities discovered during the penetration testing. Subcontractor will conduct additional penetration testing annually and report the results to the State. [See §5.1.4.2.C.21]

13. Provider, Subcontractor and subcontractors shall make all Service Coordination data, inclusive of Social Determinants of Health and Independence, available to Company and the State upon request. [See §5.4.15.D]

14. Home and Community Based Services ("HCBS") providers shall be credentialed and re-credentialed consistent with applicable Waiver Provider qualification requirements and credentialing standards identified by the State for HCBS Providers and verify HCBS Provider compliance with Federal settings requirements at 42 CFR § 441.301(c)(4). [See §5.5.1.F.3]

15. Provider and Subcontractor shall ensure that Members are provided Covered Services without regard to race, color, national origin, sex, sexual orientation, gender identity, age, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, age, or disability. [See §5.5.4.A.3]

16. Provider and Subcontractor shall incorporate in its policies, administration, and service practice the values of (i) honoring Member's beliefs, (ii) sensitivity to cultural diversity, and (iii) fostering in staff attitudes and interpersonal communication styles which respect Members' cultural backgrounds. [See §5.5.4.A.4]

17. Provider and Subcontractor shall not undertake any work that represents a potential conflict of interest, or which is not in the best interest of KDHE-DHCF or the State without written approval by KDHE-DHCF. Any work that involves LTSS or Behavioral Health Providers will need written approval from KDADS. [See §5.5.12.B]

18. The following provisions apply to any agreement wherein Company has delegated its responsibilities under the Agreement or State Contract. Provider or Subcontractor shall assist Company as necessary to successfully comply with each applicable requirement. [See §5.5.13]

    A. Subcontractor agrees to perform the delegated activities and reporting responsibilities as specified in compliance with the State Contract. Subcontractors shall fully disclose all terms and conditions, including disclosure of all financial or other requested information.
    B. Subcontractor shall pay providers at no less than the State of Kansas FFS schedule. Subcontractors are to be compliant with changes to the fee schedule by the effective date of relevant fee schedules.
    C. Subcontractor shall be subject to ongoing performance review and shall have a formal review at least annually or more frequently if requested by KDHE-DHCF. Any deficiencies shall be subject to a corrective action plan by Subcontractor. The results of the performance review and the corrective action plan shall be communicated to KDHE-DHCF upon completion.
    D. Subcontractor shall inform KDHE-DHCF in writing if a subcontractor is noncompliant to the extent it would affect its ability to perform the duties and responsibilities of the Agreement or Subcontract.
    E. Company may revoke the delegation activities or obligations or impose liquidating damages, in instances where KDHE-DHCF or Company determine that Subcontractor or a subcontractor has not performed satisfactorily.
    F. Comply with 42 CFR § 438.10(g)(2)(xi) about the Grievance and Appeal System.
    G. Each Subcontract, and, upon the request of the State, any further delegations by Subcontractor, shall be subject to review and/or written approval by Company and the State.

19. The following are minimum Subcontract Requirements. [See §5.5.14]
    A. Subcontractor agrees to comply with all applicable Medicaid laws, State laws, policies, and regulations, including applicable sub-regulatory guidance and State Contract provisions.
    B. Any services described in the Agreement that directly serve the State of Kansas or its Members and involve access to secure or sensitive data or personal Member data shall be performed within the defined territories of the United States.
    C. Subcontractor shall adhere to the requirements regarding disclosure of Ownership and control and disclosure of information on persons convicted of crimes as outlined in 42 CFR § 438.610.

D. Subcontractors and providers shall report all suspected Fraud, Waste, or Abuse to KDHE-DHCF regardless of funding source.
E. A merger, reorganization or change in Ownership of Subcontractor shall require an amendment to the Agreement and prior approval of KDHE-DHCF.
F. Subcontractor shall identify Medicare and other TPL coverage and to seek Medicare or TPL payment before submitting claims to Company.
G. Subcontractor shall safeguard confidential information in accordance with Federal and State laws, regulations, policies, and HIPAA.
H. Subcontractor must retain, as applicable, Member Grievance and Appeal records, base data and audited financial reports, and data requested to support the Company's Medical Loss Ratio (MLR) reporting requirements.
I. Subcontractor shall comply with KDHE-DHCF and the Company's quality management programs, medical management programs, and shall comply with the utilization control and review procedures in conformance with CMS rules and regulations and the KDHE-DHCF Quality Strategy.
J. KDHE-DHCF is responsible for enrollment, re-enrollment and disenrollment of the covered population.
K. Subcontractor must comply with Encounter reporting and claims submission requirements as applicable to the Company.
L. Subcontractor shall develop and follow written policies and procedures for the processing of requests for initial and continuing authorization of services.
M. Compensation to individuals or entities that conduct UM and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member.
N. Subcontractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the Member.
O. Subcontractor shall assist Members in understanding their right to file grievances and appeals in conformance with all KDHE-DHCF Grievance and Appeal System and Member rights policies.
P. Subcontractor agrees that the State, CMS, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of Subcontractor or Subcontractor's contractor(s) that pertain to any aspect of services and amounts payable under the State Contract. For purposes of an audit, evaluation, or inspection, Subcontractor shall make available its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to Members at no cost.
Q. Company may suspend, deny, refuse to renew, or terminate any Subcontract in accordance with the terms of the State Contract and applicable law and regulation.
R. Subcontractor shall maintain a fully executed original or electronic copy of all Subcontracts, which shall be accessible to Company and KDHE-DHCF within five (5) business days of request.

20. Provider and Subcontractor shall report all suspected Fraud, Waste, or Abuse to KDHE-DHCF regardless of funding source. [See §5.5.14.9]

21. Provider shall identify Provider Preventable Conditions as a condition of payment and comply with the prohibition against payment for Provider Preventable Conditions as set forth in 42 CFR § 434.6(a)(12) and 447.26. Provider shall report all Provider preventable conditions in a form and frequency as specified by Company and in accordance with KDHE-DHCF requirements. [See §5.5.15.H]

22. Subcontractor shall be responsible for developing, hosting, and maintaining a public website. [See §5.6.3.A]

23. If Provider or Subcontractor performs Customer Service pursuant to the Agreement, Subcontractor shall meet the following requirements. [See §5.6.5]
    1. 100% of incoming and outgoing calls must be documented and recorded.
    2. 99% of calls will be answered by an individual or an electronic device without receiving a busy signal.

3. 80% of all calls will be answered in thirty (30) seconds or less. The average speed for answering calls will be thirty (30) seconds or less. The average abandonment rate will be 4% or less.
4. 90% of calls answered will be resolved during the initial contact.
5. 100% of received phone calls are recorded and the recordings maintained.
6. 100% of calls left on voice mail during or after working hours will be retrieved and returned within one (1) business day.
7. 95% of all inquiries shall be resolved within two (2) business days of receipt.
8. 98% of all inquiries shall be resolved within five (5) business days.
9. 100% of all inquiries shall be resolved within fifteen (15) business days.
10. 100% of all email inquiries will be answered within one (1) business day.
11. 90% quality monthly average for fully trained staff based upon the standards of the State approved training plan.
12. 95% hold times equal to or less than one (1) minute for all inbound and outbound calls

24. If Subcontractor performs peer reviews, it will primarily utilize Kansas-licensed physicians, pharmacists and dentists to render any adverse determination regarding service requests. However, Subcontractor may utilize a non-Kansas licensed physician, pharmacist or dentist for such determinations on a short-term basis in cases of temporary absence or business disruption so long as the use of this option is reported to Company and the State on a per- use basis; the non-Kansas licensed physician, pharmacist and dentist is of equal licensure as the person for whom he/she is substituting; the non-Kansas licensed physician, pharmacist and dentist is familiar with the KanCare program and has an existing relationship with Subcontractor; and the absence or disruption does not exceed ten (10) business days or as otherwise approved by Company and KDHE. If Subcontractor intends to utilize the short- term option, Subcontractor shall first provide Company and KDHE a description of how it will be structured and implemented. [See §5.8.1.I]

25. Utilization Management (UM) activities shall not be performed unless and until approved by the State. [See §5.8.1.J]

26. Subcontractor and delegates shall comply with all requirements for State and Federal Monitoring found at 42 CFR § 438.230 and the following. [See §5.9.2]
    A. Subcontractor shall cooperate with any State or Federal monitoring of its performance under the State Contract, which may include but is not limited to external quality reviews (EQR), operational reviews, performance audits, and evaluations.
    B. Subcontractor must identify, collect and provide any data, medical records, or other information requested by the State or its authorized representative or the Federal agency or its authorized representative in the format or process specified by the State/Federal agency or its authorized representative. Subcontractor shall provide the requested data, medical records and other information at no charge and in the required timeframe to the State/Federal agency or its authorized representative.
    C. If requested, Subcontractor shall provide, at no cost, an adequate workspace at Subcontractor's local offices for the State/Federal agency or its authorized representative to review requested data, medical records, or other information.
    D. Federal law (Section 1902(a)(30)(C) of Title XIX of the SSA) requires entities which are external to and independent of the State and its contractors and subcontractors to perform, on an annual basis, a review of the quality of Medicaid MCS furnished by each such contractor or subcontractor. Requirements relating to the EQR are further defined and described under 42 CFR § 433 and 438 updated in the new managed care final rule. Subcontractor shall cooperate and participate in EQR activities in accordance with protocols identified under 42 CFR § 438, Subpart E.
        1. The external quality review organization ("EQRO") will conduct annual, external, independent reviews of the quality Outcomes, timeliness of, and access to the services covered in the Agreement and State Contract.
        2. Subcontractor shall collaborate with the EQRO to develop studies, surveys and other QAPI activities to access the quality of care and services provided to Members and to identify

opportunities for Subcontractor improvement. Subcontractor must also work collaboratively with the State and the EQRO to annually measure identified performance measures.

3. Subcontractor shall respond to recommendations made by the EQRO within the timeframe established by the EQRO. For the purposes of the Agreement and State Contract, these requirements shall apply to all Medicaid and CHIP managed care services.
4. Federal law (Section 1902(a) (30)(C) of Title XIX of the SSA) requires entities which are external to and independent of the State and its contractors and subcontractors to perform, on an annual basis, a review of the quality of Medicaid managed care services furnished by each such contractor and subcontractor.

27. Provider, Subcontractor and subcontractors shall maintain clinical and medical records in a manner that is current, detailed and organized; and, which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. [See §5.9.12.A]

28. Subcontractors with responsibility for coverage of services and payment of claims must establish arrangements or procedures that include, at a minimum the elements required in 42 CFR § 438.608(a)(1). [See §5.12.1.A]. Specifically:
    1. Written policies, procedures, and standards of conduct that articulate the Subcontractors' commitment to comply with all applicable requirements and standards under the State Contract, and all applicable Federal and State laws.
    2. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the State Contract and who reports directly to the CEO and the board of directors.
    3. The establishment of a regulatory compliance committee on the Board of Directors and at the senior management level charged with overseeing the Subcontractors' compliance program and its compliance with the requirements under the State Contract.
    4. A system for training and education for the compliance officer, the Subcontractors' senior management, and the Subcontractors' employees for the Federal and State standards under the State Contract.
    5. Effective lines of communication between the compliance officer and the Subcontractors' employees.
    6. Enforcement of standards through well-publicized disciplinary guidelines.
    7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the State Contract.

29. Providers shall be enrolled with KDHE-DHCF as Medicaid Providers consistent with the Provider disclosure, screening and enrollment requirements of 42 CFR § Part 455, subparts B and E as incorporated in 42 CFR § 438.608(b) prior to executing a Provider agreement. [See §5.12.1.C]

30. The State, or any agent including the State's Fiscal Agent, has the right to review, audit, and recover from Providers. Subcontractors have a duty to cooperate with reviews and audits and must respond to State requests. [See §5.12.1.F]

31. Providers shall report overpayments and specify the reason for the overpayment in writing. The overpayment shall be returned to the Company within sixty (60) calendar days after the date on which the payment was identified. [See §5.12.1.L.3]

32. Subcontractor shall comply with 42 CFR § 455.23 by suspending all payments to a Provider after KDHE-DHCF determines that there is a credible allegation of Fraud for which an investigation is pending under the Medicaid program against an individual or entity unless KDHE-DHCF has identified in writing a good cause reason for not suspending payments or to suspend payments only in part. Subcontractor shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR §

455.23(b) and maintain the suspension for the durational period set forth in 42 CFR § 455.23(c). In addition, the notice of payment suspension shall state that payments are being withheld in accordance with 42 CFR § 455.23(g). Subcontractor shall maintain all materials related to payment suspensions for a minimum of five (5) years in compliance with the obligations set forth in 42 CFR § 455.23(g). [See §5.12.1.N]

33. Providers shall disclose the identity of any person described in 42 CFR § 1001.1001(a)(1). [See §5.12.1.Q]

34. Subcontractor may not knowingly have a relationship with any of the following. [See §5.12.R.1]
    a. An individual or entity who is 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.
    b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of an individual or entity described in Section 5.12.1.R.1.a.

35. Subcontractor may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the SSA. [See §5.12.1.R.3]

36. Any Provider or Subcontractor that receives or makes $5 million in annual payments from KDHE-DHCF, must comply with section 1902(a)(68) of the SSA and 42 CFR § 438.608(a)(6) as a condition of receiving payment. The $5 million amount will be based on paid claims, net of any adjustments to those claims. It will be the responsibility of Provider or Subcontractor to make the determination as to whether they meet the $5 million threshold. To comply with Section 1902(a)(68) of the SSA and 42 CFR § 438.608(a)(6), the Provider or Subcontractor must ensure that it has implemented all of the following requirements. [See §5.12.1.R.5]
    a. Must establish written policies that provide detailed information about the Federal laws identified in Section 1902(a)(68) of the SSA and any State laws imposing civil or criminal penalties for false claims and statements, or providing whistleblower protections under such laws.
    b. In addition to the detailed information regarding the Federal and State laws, the written policies must contain detailed information regarding the policies and procedures to detect and prevent Fraud, Waste, or Abuse in Federal health care programs, including the Medicare and Medicare Advantage Programs.
    c. Must provide a copy of its written policies to all of its employees, contractors and agents of the vendor.
    d. If Provider or Subcontractor maintains an employee handbook, the handbook must include a specific discussion of the Federal and State laws described in its written policies, policies and procedures for detecting and preventing Fraud, Waste, or Abuse and the right of its employees to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act or otherwise makes a good faith report alleging Fraud, Waste, or Abuse in a Federal health care program, including the Medicare and KDHE-DHCF Programs, to the Provider, Subcontractor, or to the appropriate authorities.

37. Provider and Subcontractor shall conduct program integrity data analytics specific to Kansas data. [See §5.12.1.R.7.d]

38. Claims shall be filed within one-hundred eighty (180) calendar days from the date of service, and a three hundred and sixty five (365) calendar day limit shall apply for any correction or rebilling of a timely filed claim. [See §5.14.1.H.2]

39. Provider, Subcontractor and subcontractors with access to Protected Health Information shall comply with the Health Insurance Portability and Accountability Act and Health Information Technology for Economic and Clinical Health Act. Subcontractors shall comply with 45 CFR § 205.50, and 42 CFR § Part 2, Safeguarding Information for the Financial Assistance and Social Service Program, 42 CFR § 431 Subpart F, as well as 41 USC 423 27. Provider, Subcontractor and subcontractors must comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, 42 CFR § Part 2, etc.) and other laws regarding privacy and confidentiality. As deemed necessary, the State or its designated

agent, and the Federal government shall be allowed access to this data. All information, except as noted above, as to personal facts and circumstances shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the State and the written consent of the Member, or his/her attorney, or his/her responsible parent or guardian. [See §5.15.2]

40. For a period of ten (10) years after termination of the State Contract or from the date of completion of an audit in accordance with 42 CFR § 438.3(h), Provider, Subcontractor and subcontractors shall provide to any duly authorized representative of the State or Federal government access to its premises, during normal business hours, for the purpose of inspecting, monitoring, auditing and reproducing records and materials created pursuant to the provision of contractual activities under the Agreement or State Contract. Provider, Subcontractor and subcontractors shall make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal representatives conducting the audit or inspection effort. [See §5.16.1.F]

41. Subcontractor shall upon request provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal representatives conducting the audit or inspection effort. [See §5.16.1.H]

42. Provider, Subcontractor and subcontractors shall inform their employees working on any Federal award they are subject to the whistleblower protections under 41 U.S.C. 4712. [See §5.22]

43. Provider, Subcontractor and subcontractors shall preserve and make available at reasonable times all of its books, documents, papers, records, and other evidence involving transactions related to State Contract for a period of no less than ten (10) years from the date of the expiration or termination of the State Contract. Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds five (5) years. Authorized Federal and State representatives, including but not limited to, personnel of the using agency; independent auditors acting on behalf of state and/or Federal agencies shall be permitted access to and the right to examine records and access the physical premises during the State Contract period, and during the ten (10) years post State Contract period or ten (10) years from the date of completion of any audit, whichever is later. Delivery of and access to the records shall be within five (5) business days at no cost to the State. [See §5.24]

44. Subcontractor shall forward to the State a report indicating when the Front End Billing ("FEB") related files were loaded into its system. Subcontractor will work with the State regarding the required format and data elements. [See Attachment I, §1.5.7]

45. Any Provider or Subcontractor authorized to process and pay claims shall process 90% of Clean Claims within 10 days of receipt. [State checklist]

The following definitions from the State Contract shall replace any contradictory definitions in the Agreement:

Appeal	A request for a review by Company of an Adverse Benefit Determination, as "Adverse Benefit Determination" is defined in 42 CFR § 438.400, or an Action, as "Action" is defined in the State Agreement.
Clean Claim	A claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It does not include a claim from a provider who is under investigation for Fraud or Abuse, or a claim under review for Medical Necessity.
Emergency Care	A. All emergency care is immediate, at the nearest facility available, regardless of whether the Emergency Room (ER) is a Participating Provider. B. Emergency services must be available twenty-four (24) hours a day, seven (7) days a week.
Grievance	An expression of dissatisfaction about any matter other than an Adverse Benefit Determination, as "Adverse Benefit Determination" is defined in the State Contract, or an Action.
Medical Necessity	Defined in K.A.R. 30-5-58. In addition, Company is responsible for covering services related to the following: (1) The prevention, diagnosis, and treatment of health impairments. (2) The ability to achieve age-appropriate growth and development. (3) The ability to attain, maintain or regain functional capacity.
Member	A Title XIX or Title XXI Beneficiary who has been certified by the State as eligible to enroll and whose name appears on Company's enrollment information.
Post-Pay Recovery and Third Party Liability (TPL)	TPL refers to any individual, entity or program that may be liable for all or part of a Member's health coverage. Under section 1902(a)(25) of the SSA, the State is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid Member. Company shall also follow all Federal regulations and all State of Kansas statutes and regulations for TPL and medical Subrogation. Company shall have procedures in place to collect TPL funds when primary coverage is identified after payment has been made.
Prior Authorization	Approval granted for payment purposes by Company to a Provider to provide specified Covered Services to a specified Member.
Prudent Lay Person	A person who possesses an average knowledge about health, health care, and medicine.
Specialty Care and Urgent Care	Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, rehabilitation services, etc.) shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care and waiting times shall not exceed forty-five (45) minutes.
State Fair Hearing (SFH)	An administrative hearing involving the presentation of evidence and argument before a presiding officer from the Kansas Office of Administrative Hearings concerning an Adverse Benefit Determination or an Action.
Telemedicine	Connecting Participating Providers with Members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication.
Telementoring	Technologies such as the Project ECHO model to connect community primary care providers with specialists remotely located to provide consultations, grand rounds, education, and to fully extend the range of care available within a community practice.
Telemonitoring	Technologies that target specific disease type (i.e., congestive heart failure) or high utilizers of health services, particularly emergency room services and medication regimen management. Technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing provider. The provider, who might be a physician, nurse, social worker, or even a non-clinical staff Member, can filter Member questions and report to a clinical team as necessary.
Timely Filing	Company will adopt and implement standardized timely filing requirements, applying a one-hundred eighty (180) calendar day filing limit for all claims for all services, and a 365 day limit for any correction or rebilling of a timely filed claim, unless the Provider agrees through the Agreement to an alternate timely filing timeframe.

Exhibit B-15

CALIFORNIA MEDICAID COMPLIANCE ADDENDUM (VENDOR)

This California Compliance Addendum ("Addendum") is made part of the Agreement entered into between Company and Vendor. Company and Vendor each agree to be bound by the terms and conditions contained in both Article I and Article II of this Addendum. In the event of a conflict or inconsistency between this Addendum and any term or condition contained in the Agreement, this Addendum shall apply. Vendor shall also include the terms of this Addendum in any subcontracts entered into in connection with the Agreement. For purposes of this California Compliance Addendum, the term "Vendor" shall mean the business entity executing the Agreement, as identified on the first page of the Agreement.

This Addendum will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes. Unless otherwise defined in this Addendum, all capitalized terms contained in this Addendum will be defined as set forth in the Agreement.

The California Department of Managed Health Care ("DMHC") regulates products governed by the Knox-Keene Act. The DMHC's address is 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725, and the DMHC's website is www.dmhc.ca.gov.

Article I. Knox-Keene Act Administrative Service Delegation and Oversight Requirements

1.1 Control Retained in Company. Company shall, throughout the term of the Agreement, exercise ultimate control over its assets and operations.

1.2 Company Policies and Procedures. Company's Board of Directors shall be and remain ultimately responsible for the development, approval and implementation of policies and procedures for Company's operations. Company shall review, at least annually, for accuracy and potential updates, the policies and procedures for Company's functions that are delegated under the Agreement. Changes to these policies and procedures resulting from this review shall be made and distributed by Company to Vendor within two weeks after completion of the revisions to the policies and procedures.

1.3 Delegated Functions and Oversight. Company shall supervise all medical, professional, and ethical affairs of its business and shall establish general operating policies. Company shall designate oversight personnel to oversee the functional manager of the delegated functions. Vendor shall perform or arrange for the provision of the functions described in the Agreement in accordance with the policies and directives and standards of performance given to Vendor by Company in the Agreement and with adequate staffing and resources, including information technology, as needed to result in compliance with the Knox- Keene Act.

1.4 Policy Recommendations and Proposals. Company may adopt policy recommendations or proposals made by Vendor. Company will, according to the terms of the Agreement, direct Vendor to implement existing or future policies, which Vendor shall implement in the performance of services under the Agreement.

1.5 Monitoring. Company shall perform periodic monitoring evaluations, at least annually, to monitor the functions delegated under the Agreement. For purposes of the Agreement, "periodic monitoring evaluations" means the following: a review of operational metrics to ensure performance meets state regulatory requirements. "Periodic monitoring evaluations" also means that, at least annually, Company shall perform an audit on-site at the offices of Vendor and at any other location(s) where delegated functions, such as pharmacy, are performed by other entities. Company shall generate a written report documenting the on-site audit procedures, findings and corrective actions taken to resolve deficiencies, if any, identified in the audit.

1.6 Limitations on Delegation. By entering into the Agreement, Company has not delegated any of the powers, duties, and responsibilities required to be performed by Company under any statute, ordinance, code, or other law, rule, regulation, order, standard, requirement or procedure enacted, adopted, promulgated, applied or followed by any governmental authority or court, judge, justice, magistrate, including the Knox-Keene Act.

1.7 Monitoring and Oversight of Services. The provision or arrangement by Vendor of services pursuant to the Agreement shall at all times be subject to the supervision and authority of Company, which shall retain discretion and authority to direct and control any aspect of Vendor's provision or arrangement of such services. Company shall implement a system for continuous monitoring and oversight of Vendor's services to ensure that Vendor's provision or arrangement of services pursuant to the Agreement complies with all applicable law, including but not limited to the Knox-Keene Act. Such monitoring and oversight system shall include the following:

A. Monthly Operations Reports. Vendor shall provide monthly operations reports to Company that include adequately detailed data elements to present an accurate report of Vendor's performance. If and to the extent that Vendor provides the following types of services, such monthly operations reports shall include, at a minimum: medical and clinical management services reports, accounts payable processing reports, payroll reports, periodic ad hoc financial reports, tax payment reports, incurred but not reported claims reports, claims performance reports, customer services performance reports, and intercompany transaction and investment reports.

B. Special Reports. Vendor shall prepare and submit to Company's management any special reports as requested by Company regarding any proposed or rendered Services under the Agreement.

C. Notices of Deficiency and Corrective Action Plans. Company's oversight shall include, but shall not be limited to, notices of deficiencies to Vendor and establishment of corrective action plans. For deficiencies in Vendor's services which Company determines are capable of being corrected, Company shall provide Vendor with written notice of deficiency and shall specify the corrective actions to be taken by Vendor and a timeline to correct the identified deficiency. Vendor shall cooperate with the corrective action plan and comply with the reasonable timelines established by Company.

1.8 Removal of Records. The Parties shall not remove, or require, permit, or cause the removal of their books and records, as defined in the Knox-Keene Act, from California before filing a Notice of Material Modification and receiving written approval from the DMHC, as applicable. Notwithstanding any failure or omission on a Party's part, or that of an Affiliate, to maintain Company's records in California, the Parties agree that they shall return to California, as may be required by the DMHC, within the timeframe specified by the DMHC, any such books and records that have been removed from California without the DMHC's express, written permission. This provision shall not restrict the Parties from maintaining books and records in an electronic format, as long as electronic books and records are contemporaneously available in California.

1.9 Access to Records. Upon demand by Company, Vendor shall provide Company with access, at reasonable times, to inspect books, papers and records relating to the performance of the Agreement by Vendor.

1.10 Maintenance of Records. The Parties shall maintain for two (2) years at their principal administrative offices adequate books and records of all transactions related to the services provided pursuant to the Agreement. The Parties shall maintain such books and records for the duration of the Agreement and for a period of not less than five (5) years thereafter, unless a different retention period is specified by applicable law, then such books and records shall be maintained for such period as required by applicable law. The DMHC and any other regulatory authority with jurisdiction over the Agreement shall have access to books and records maintained by the Parties for the purpose of examination, audit, inspection and investigation during normal business hours.

1.11 Disaster Recovery Program. With respect to all records related to services provided pursuant to the Agreement, Vendor shall comply with Vendor's disaster recovery program.

Article II. Provisions applicable to California Medi-Cal Plans as required by the California Department of Health Care Services and the State Contract.

Vendor acknowledges that Company is a party to the State Contract which requires that certain terms and conditions be included in contracts with contracting entities such as Vendor. This Article sets forth such requirements as well as related requirements under the laws of California, which are in addition those requirements set forth elsewhere in the Agreement. To the extent that the terms and conditions of the Agreement directly conflict with or contradict any terms and conditions set forth in this Article, the terms and conditions of this Article shall control. Defined terms that are not otherwise defined in this Article or the Agreement shall have the meaning set forth in the State Contract. In addition, terms utilized in Sections 2.42 and 2.43 and in Appendix A shall have the meaning set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") if not defined in the Agreement, this Addendum, or the State Contract.

2.1 Vendor agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying: (A) By the California Department of Health Care Services ("DHCS"), the United States Centers for Medicare and Medicaid Services ("CMS"), the United States Department of Health and Human Services ("DHHS") Inspector General, the Comptroller General of the United States, the United States Department of Justice, DMHC, or their designees; (B) At all reasonable times at the Vendor's place of business or at such other mutually agreeable location in California; (C) In a form maintained in accordance with the general standards applicable to such book or record keeping; (D) For a term of at least ten (10) years from the final date of the State Contract period or from the date of completion of any audit, whichever is later, or such longer period as required by Law; (E) Including all encounter data for a period of at least ten (10) years, or such longer period as required by Law; (F) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS or the DHHS Inspector General may inspect, evaluate, and audit the Vendor at any time; and (G) Vendor acknowledges that upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate Vendor from participation in the Medi-Cal Program, seek recovery of payments made to Vendor, impose other sanctions provided under the State Contract, and direct Company to terminate the Agreement due to fraud. [[State Contract Exhibit A, Attachment 6, No. 14.B.8 & 14.B.10; Exhibit E, Attachment 2, No. 19 & 20; 22 CCR 53250(e)(1); Exhibit G, No. III.H; Exhibit G, No. V.A]]

2.2 Vendor shall provide Company, within the time requested by Company, with all such reports and information as Company may require to allow it to meet the reporting requirements under the State Contract or any applicable Law. [[State Contract Exhibit A, Attachment 6, No. 14.B.6; Exhibit A, Attachment 2 Nos. 3 and 10.A; Exhibit A, Attachment 3 No. 2; 22 CCR § 53250(c)(5)]]

2.3 To the extent applicable, if the State Contract with the Company terminates for any reason, Vendor will assist the Company in the transfer of care pursuant to State Contract Exhibit E, Attachment 2, No. 15 Phase Out Requirements. [[State Contract Exhibit A, Attachment 6, No. 14.B.11, Exhibit E, Attachment 2, No. 15]

2.4 Vendor shall notify DHCS in the event the Agreement is terminated. Notice to the Department is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. [[State Contract Exhibit A, Attachment 6, No. 14.B.13]]

2.5 Vendor agrees that the assignment or delegation of any part of the Agreement shall be void unless prior written approval is obtained from DHCS. [[State Contract Exhibit A, Attachment 6, No. 14.B.14]]

2.6 To the extent applicable, Vendor shall ensure that Members are informed of the full array of covered contraceptive methods when appropriate and that informed consent is obtained from Members for

sterilization consistent with requirements of applicable Law. [[22 CCR §§ 51305.1, 51305.3; State Contract Exhibit A, Attachment 9, No. 9.A]]

2.7 To the extent applicable, Vendor shall comply with the Medi-Cal Minor Consent Services program. Minors do not need parental consent in order to access services related to sexual assault, including rape, drug or alcohol abuse (for children 12 years of age or older), pregnancy, family planning, and STDs and HIV/AIDS (in children 12 years of age or older). [[State Contract Exhibit A, Attachment 9, No. 9.D]]

2.8 Vendor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Vendor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Vendor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Vendor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees. [[State Contract Exhibit D(F) , No. 1-A]]

2.9 Vendor will, in all solicitations or advancements for employees placed by or on behalf of Vendor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. [[State Contract Exhibit D(F), No. 1-B]]

2.10 Vendor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Vendor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [[State Contract Exhibit D(F), No. 1-C]]

2.11 Vendor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 C.F.R. 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor. [[State Contract Exhibit D(F), No. 1-D]]

2.12 Vendor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 C.F.R. 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders. [[State Contract Exhibit D(F), No. 1-E]]

2.13 In the event of the Vendor's noncompliance with the requirements of the provisions herein or with any Federal rules, regulations, or orders which are referenced herein, the Agreement may be cancelled, terminated, or suspended in whole or in part and the Vendor may be declared ineligible for further Federal

and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 C.F.R. 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law. [[State Contract Exhibit D(F), No. 1-F]]

2.14 By signing the Agreement, Vendor agrees that if any performance under the Agreement includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 U.S.C. Section 263a (CLIA) and the regulations thereto. [[State Contract Exhibit A, Attachment 4 No. 12(A)]]

2.15 Smoke-Free Workplace Certification

A. The following provisions only apply to Vendors that provide "children's services" as described in Public Law 103-227 (the Pro-Children Act of 1994). "Children's services" means the provision on a routine or regular basis of health, day care, education, or library services—
   a. that are funded, after March 31, 1994, directly by the Federal Government or through State or local governments, by Federal grant, loan, loan guarantee, or contract programs—
      i. administered by either the Secretary of Health and Human Services or the Secretary of Education (other than services provided and funded solely under titles XVIII and XIX of the Social Security Act [42 U.S.C.A. §§ 1395 et seq. and 1396 et seq.]); or
      ii. administered by the Secretary of Agriculture in the case of a clinic (as defined in 7 C.F.R. 246.2) under section 17(b)(6) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(6)), or
   b. that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds, as determined by the appropriate Secretary in any enforcement action under this subchapter. 20 U.S.C. § 6082.

B. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

C. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

D. By signing the Agreement, Vendor certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

E. The Company must insert this certification into any subcontracts entered into that provide for children's services as described in the Act. [[State Contract, Exhibit D(F), No. 20; Public Law 103-227]]

2.16 Vendor shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to the State Contract or persons whose names or identifying

information become available or are disclosed to the Company, its employees, agents, or subcontractors as a result of services performed under the State Contract, except for statistical information not identifying any such person. Vendor shall not use such identifying information for any purpose other than carrying out the Company's and Vendor's obligations under the State Contract. Vendor shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the Member. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will be attached to the Agreement or incorporated into the Agreement by reference. [[State Contract, Exhibit D(F), No. 13]]

2.17 If Vendor is required to file monthly Financial Statements with DMHC, Vendor shall file an exact copy of the monthly Financial Statements with DHCS. Vendor shall submit monthly financial statements to the DHCS upon request, if deemed necessary, to monitor Vendor's financial viability. [[State Contract Exhibit A, Attachment 2, No. 4]]

2.18 Lobbying. If the Agreement involves a sub-award of $100,000 or more to Vendor, Vendor agrees to comply with the following requirements related to lobbying:

A. Prohibition on Use of Federal Funds for Lobbying: Vendor certifies to the best of Vendor's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 C.F.R. 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Vendor's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

B. Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Vendor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. [[State Contract Exhibit D, No.14]]

2.19 Vendor shall maintain and make available to DHCS, upon request, copies of all Vendor's subcontracts under the Agreement and to ensure that all such sub-subcontracts are in writing and require that the subcontractor: (1) makes all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems relating to the State Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees, and (2) retain such books and records for a term of at least ten (10) years from the final date of the State Contract period or from the date of completion of any audit, whichever is later. [[State Contract Exhibit A, Attachment 6, No.14.B.10; 22 CCR § 53250(e)(3)]]

2.20 Vendor agrees to assist Company in the transfer of care in the event of a Company sub-subcontract termination for any reason. [[State Contract Exhibit A, Attachment 6, No.14.B.12]]

2.21 Vendor shall comply with all monitoring provisions of the State Agreement and any monitoring request by DHCS. [[State Contract Exhibit A, Attachment 6, No.14.B.7]]

2.22 Vendor agrees to timely gather, preserve, and provide to DHCS, any records in Vendor's possession, in accordance with the State Contract's requirements for records related to recovery for litigation. [[State Contract, Exhibit A, Attachment 6, No.14.B.16]]

2.23 Vendor agrees to provide interpreter services for Members at all Vendor sites. [[State Contract, Exhibit A, Attachment 6, No.14.B.17]]

2.24 Vendor has the right to submit a grievance in accordance with Company's process to resolve provider grievances. [[State Contract, Exhibit A, Attachment 6, No. 14.B.18]]

2.25 Vendor shall provide Company with any necessary disclosure statements including: 1) the statement set forth in Title 22 CCR Section 51000.35, and available at: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/14enrollment_DHCS6216.pdf; 2) a completed disclosure form, attached to this Addendum, for officers and other persons associated with Vendor as required by California Welfare & Institutions Code § 14452(a); and 3) and a completed Conflict of Interest Compliance Certificate, attached to this Addendum. [[State Contract, Exhibit A, Attachment 6, No.14.B.23 and 14.E; RFA 2015, Attachment 5]]

2.26 The Agreement shall be governed by and construed in accordance with all laws and contractual obligations incumbent upon Company. Vendor shall comply with all applicable Law, now or hereafter in effect, to the extent that they directly or indirectly affect Vendor or Company, and bear upon the subject matter of the Agreement. Vendor shall comply with the applicable provisions of the State Contract, and Chapters 3 and 4 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations related to the services Vendor is required to perform. In addition, Company is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in the Agreement by either of the above laws shall bind the Parties whether or not provided in the Agreement. [[State Contract, Exhibit A, Attachment 6, No.14.B.2 and 14.B.21; W&I § 14452(a); 22 CCR § 53250(c)(2); Knox-Keene Act]]

2.27 When required by law, amendments to the Agreement shall be submitted by Company to the DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes, which are neither approved nor disapproved by DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later. Subcontracts between Company and Vendor shall be public records on file with the DHCS. [[State Contract, Exhibit A, Attachment 6, No.14.B.3, 14.C.2 & 14.E; 22 CCR §§ 53250(a), (c)(3), & (e)(4)]]

2.28 Vendor shall submit financial information consistent with DMHC filing requirements unless otherwise specified by DHCS [[State Contract, Exhibit A, Attachment 2, No. 3.C]]

2.29 If Company delegates quality improvement functions to Vendor, Company and Vendor agree that such functions shall be performed in a manner consistent with Medi-Cal requirements and the Agreement shall contain the following: (a) a description of the quality improvement responsibilities, and specific delegated functions and activities; (b) Company's oversight, monitoring, and evaluation processes and Vendor's agreement to such processes; (c) Company's reporting requirements and approval processes; (d) Vendor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly; and (d) Company's actions/remedies if Vendor's obligations are not met. [[State Contract, Exhibit A, Attachment 6, No. 14.B.20; State Contract Exhibit A, Attachment 4, No.6]]

2.30 Except in specified circumstances, Vendor shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under the State Contract from a Medi-Cal Member or person acting on behalf of Member. Collection of claims may be made under those circumstances described in 22 CCR 53866, 53220, and 53222. [[State Contract, Exhibit A, Attachment 8, No. 6]]

2.31 Vendor shall ensure that medical decisions are not unduly influenced by fiscal or administrative management. [[State Contract Exhibit A, Attachment 1, No. 5]]

2.32 In the event that CMS, DHCS, or Company determines that Vendor has not performed delegation activities and reporting requirements satisfactorily, they may revoke the delegation activities or obligations (including reporting requirements), or specify other remedies. [[State Contract Exhibit A, Attachment 6, No. 14.B.22]]

2.33 Company shall share any utilization data that Company receives from DHCS with Vendor. Vendor agrees to receive and use the utilization data as able for the purpose of Member care coordination. To the extent that Vendor is not equipped to receive the utilization data, Company shall make it available to Vendor. [[State Contract Exhibit A, Attachment 6, No. 14.B.23; Exhibit A, Attachment 13, No. 7.G]

2.34 Company agrees to inform Vendor of prospective requirements added by DHCS before the requirement would be effective, and Vendor agrees to comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by DHCS and to the extent possible. [[State Contract Exhibit A, Attachment 6 No. 14.B.24]]

2.35 To the extent applicable, when Vendor provides Emergency Services to a Member and such Member's treatment requires the use of drugs, Vendor shall provide to the Member at least a 72-hour supply of Medically Necessary drugs, which may include an initial dose and a prescription for additional drugs. [[State Contract Exhibit A, Attachment 10, No. 8.G.3]]

2.36 Vendor shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act; and all other laws regarding privacy and confidentiality. [[State Contract Exhibit E, Attachment 2, No. 29]]

2.37 Vendor shall provide written disclosure of any prohibited affiliation under 42 CFR 438.610, provide written disclosures of information on ownership and control as required under 42 CFR 455.104, and report to DHCS within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of the amounts specified in the State Contract. [[State Contract Exhibit E, Attachment 2, No. 33]]

2.38 To the extent applicable, Vendor shall maintain a provider enrollment agreement with DHCS pursuant to Social Security Act Section 1902(a)(27) and Welfare and Institutions Code Section 14043.1 and in accordance with Medi-Cal Managed Care Division Policy Letter 17-019. [[APL 17-019]]

2.39 To the extent Company delegates responsibility for coverage of services and payment of claims, Vendor shall implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse. The procedures must include a compliance program, as set forth in 42 CFR 438.608(a), and contain the required elements from the State Contract. [[State Contract, Exhibit E, Attachment 2, No. 26(B)]]

2.40 Compensation of staff or subcontractors that conduct utilization management activities shall not be structured to provide incentives to deny, limit, or discontinue Medically Necessary services. [[State Contract, Exhibit A, Attachment 5, No. 1(B)]]

2.41 To the extent applicable, Vendor shall notify Company within five (5) business days of either of the following: i) the Vendor or one of its participating providers is no longer accepting new patients; or ii) the Vendor or one of its participating providers had previously not accepted new patients, but is currently accepting new patients. [[H&S Code Section 1367.27(j)]]

2.42 Vendor shall comply with all applicable provisions of HIPAA, the Health Information Technology for Economic and Clinical Health ("HITECH") Act and the HIPAA regulations in accordance with federal and state law and the State Contract. Certain required terms are listed below; however Vendor must reference

the publicly accessible State Contract for all the comprehensive requirements, which include definitions, forms, reports, deadlines and detailed instructions for protecting Protected Health Information ("PHI") and Personal Information ("PI"). [[State Contract, Exhibit G, HIPAA]]

2.43 Vendor, its Business Associates, agents and subcontractors, acting on Company's behalf under the State Contract shall protect the privacy and security of the PHI and PI created, received, maintained, transmitted, used or disclosed pursuant to the Agreement. Accordingly, Vendor agrees as follows:

2.43.1 To comply with all of the data system security precautions listed in Appendix A, Additional Security Requirements. [[State Contract, Exhibit G.III.C.3]]

2.43.2 To comply and to enter into written agreements requiring any and all of its agents, including subcontractors and vendors, to comply with the same restrictions and conditions that apply to Company with respect to PHI and PI under the State Contract, and to comply with all applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, including the implementation of reasonable and appropriate administrative, physical, and technical safeguards to protect PHI and PI. [[State Contract, Exhibit G.III.E.1]]

2.43.3 To incorporate, as applicable, the relevant provisions of this Addendum and the State Contract into each Vendor subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Company timely, per the State Contract. [[State Contract, Exhibit G, HIPAA, No. III.E.1]]

2.43.4 To comply with all applicable information availability requirements of the State Contract, including but not limited to, providing access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524. Vendor shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none. [[State Contract, Exhibit G, No. III.F.1]]

2.43.5 If Vendor maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, to provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e). [[State Contract, Exhibit G, No. III.F.2]]

2.43.6 If Vendor receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by Company or DHCS, to provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents. [[State Contract, Exhibit G, No. III.F.3]]

2.43.7 To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS. [[State Contract, Exhibit G, No. III.G]]

2.43.8 To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Vendor maintains electronic health records for DHCS as of January 1, 2009, Vendor must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Vendor acquires electronic health records for DHCS after January 1, 2009, Vendor must provide an accounting of disclosures, including those disclosures for treatment,

payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three (3) years prior to the request for an accounting. [[State Contract, Exhibit G, No. III.I]]

2.43.9 To implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps: [[State Contract, Exhibit G, No. III.J.1 - 6]]

- To notify Company and DHCS immediately by telephone call plus email or fax upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration.
- To notify Company and DHCS within twenty-four (24) hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of the Agreement or State Contract, or potential loss of confidential data affecting the State Contract in the manner outlined in the State Contract.
- To immediately investigate any security incident, breach, or unauthorized access, use or disclosure of PHI or PI and to submit all required reports, updates, conclusions and corrective action plans in accordance with the instructions outlined in the State Contract.
- If the cause of a breach of PHI or PI is attributable to Vendor or its subcontractors, agents or vendors, Vendor shall notify Company and work with Company to provide notice to individuals of the breach or unauthorized use or disclosure when notification is required under Law and shall pay any costs of such notifications, as well as any costs associated with the breach. Prior to notification, Vendor shall receive approval from DHCS officials and other government agencies, where required under the State Contract or Law, regarding the time, manner, and content of such notifications.

2.43.10 To promptly remedy any violation of any provision of Exhibit G of the State Contract caused by Vendor and to certify the same to the DHCS Privacy Officer in writing. [[State Contract, Exhibit G, No. V.A]]

2.43.11 If Vendor is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this Addendum, to notify Company and DHCS and provide Company and DHCS with a copy of any PHI or PI that Vendor provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Vendor is responsible for any civil penalties assessed due to an audit or investigation of Vendor, in accordance with 42 U.S.C. Section 17934(c). [[State Contract, Exhibit G, No. V.B]]

2.43.12 The term of this Addendum shall extend beyond the termination of the Agreement and shall terminate when all the PHI provided by DHCS to Vendor, or created or received by Vendor on behalf of DHCS, is destroyed or returned to DHCS, to the extent and as directed by DHCS and in accordance with 45 CFR 164.504(e)(2)(ii)(I). [[State Contract, Exhibit G, No. VI.A]]

2.43.13 To notify Company and DHCS if Vendor is named as a defendant in a criminal proceeding for a violation of HIPAA. Company or DHCS may terminate the Agreement if Vendor is found guilty of a criminal violation of HIPAA. Company or DHCS may terminate the Agreement if a finding or stipulation that the Vendor has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which Vendor is a party or has been joined. [[State Contract, Exhibit G, No. VI.D]]

2.43.14 To promptly enter into negotiations with Company and DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of

HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. Company or DHCS may terminate the Agreement upon thirty (30) days written notice in the event: (a) Vendor does not promptly enter into negotiations to amend this Addendum when requested by Company or DHCS pursuant to this Section, or (b) Vendor does not enter into an amendment providing assurances regarding the safeguarding of PHI that Company and DHCS, in their sole discretion, deem sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations. [[State Contract, Exhibit G, No. VII.B]]

2.43.15 To make itself available to DHCS at no cost to DHCS to testify as a witness, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Vendor, except where Vendor is a named adverse party. [[State Contract Exhibit G, No. VII.C]]

DISCLOSURE FORM

(Required by California Welfare and Institutions Code Section 14452)

The undersigned hereby certifies that the following information regarding:

_____
(The "Organization") is true and correct as of the date set forth below:

Officers/Directors/General Partners:

_____

_____

Co-Owner(s):

_____
_____

Stockholders owning more than ten percent of the stock of the Organization:

_____
_____
_____

Major creditors holding more than five percent of Organization's debt:

_____
_____
_____

Form of Organization (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____
_____
_____

If not already disclosed above, is Organization, either directly or indirectly related to or affiliated with the Contracting Health Plan? Please explain:

_____
_____
_____

Dated:_____

Signature:_____

Name:_____
(Please type or print)

Title:_____
(Please type or print)

CONFLICT OF INTEREST COMPLIANCE CERTIFICATE

A. DHCS intends to avoid conflicts of interest or the appearance of conflicts of interest on the part of the Contractor, subcontractors, or employees, officers and directors of the Contractor or subcontractors. Thus, DHCS reserves the right to determine, at its sole discretion, whether any information received from any source indicates the existence of a conflict of interest.

B. Either of the following instances would be considered a "conflict of interest", including, but not limited to:

   1. An instance where the Contractor or any of its subcontractors, or any employee, officer, or director of the Contractor or any subcontractor has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the contract would allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of the contract.

   2. An instance where the Contractor's or any subcontractor's employees, officers, or directors use their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business or other ties.

   3. Any other conflict of interest identified in federal or State statute or regulation.

C. If any proposed subcontractor has a suspected or potential conflict of interest, the proposed subcontractor shall attach to this form a description of the activity, a plan for ensuring that the activity will not adversely affect DHCS, and procedures to guard against the existence of an actual conflict of interest. Based on that information, and any other information DHCS may require, DHCS will determine whether a conflict of interest exists and whether it can be resolved to the satisfaction of DHCS.

D. This Certificate shall bear the signature of an official or employee of the proposed subcontractor who is authorized to bind the proposed subcontractor.

E. It is understood that the requirements set forth in this Certificate shall be in effect for the entire term of the State Contract.

F. Company or Plan shall obtain a completed Certificate from any proposed subcontractor and submit it to DHCS prior to approval of the subcontractor by DHCS.

G. Each subcontractor shall notify DHCS, Managed Care Operations Division within ten (10) working days of any change to the information provided on or attached to this Certificate.

H. If DHCS becomes aware of a suspected or potential conflict of interest, the subcontractor will be given an opportunity to submit additional information as described in Paragraph C above or to resolve the conflict. The subcontractor will have five (5) working days from the date of notification of the conflict by DHCS to provide complete information regarding the conflict. If DHCS determines that a conflict of interest exists and it cannot be resolved to the satisfaction of DHCS, before or after the award of the contract, the conflict will be grounds for termination of the subcontract.

The undersigned herby affirms that: (check one)

☐ The statements above have been read and that no conflict of interest exists that would jeopardize the ability of the proposed subcontractor to perform independently from DHCS' influence.

☐ A suspected or potential conflict of interest does exist, and additional information (as described B.3. above) is attached along with a plan to address the possible conflict of interest.

Signed: _____ **Title:** _____ **Date:** _____

Typed or Printed Name of Authorized Representative: _____

APPENDIX A – ADDITIONAL SECURITY REQUIREMENTS

To the extent applicable to Vendor as a subcontractor to Company under the State Contract with DHCS, or as otherwise required by Law, Vendor agrees to implement a written information privacy and security program (which must be provided to Company upon reasonable request) that implements steps to ensure the continuous security of all computerized data systems containing PHI. Such steps shall include, at a minimum:

- Complying with all of the data system security precautions listed below in this Appendix A;
- Achieving and maintaining compliance with 45 C.F.R. Parts 160 and 164, subparts A and C, as necessary in conducting operations on behalf of Company under the State Contract;
- Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in federal agencies; and
- In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Vendor must comply with changes to these standards that occur after the effective date of the State Contract.

1. Personnel Controls

A. ***Employee Identification***: Vendor shall maintain a current list of its employees, agents, and Subcontractors with access to PHI provided by Company. Upon request, Vendor shall provide such list to Company within a reasonable amount of time.

B. ***Employee Training.*** All workforce members who assist in the performance of functions or activities on behalf of Company, or access or disclose Company PHI must complete information privacy and security training, at least annually, at Vendor's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following termination of the Agreement.

C. ***Employee Discipline.*** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

D. ***Confidentiality Statement.*** All persons that will be working with Company PHI must sign a confidentiality statement that includes, at a minimum, general use, security and privacy safeguards, unacceptable use, and enforcement policies. The statement must be signed by the workforce member prior to access to Company PHI. The statement must be renewed annually. The Vendor shall retain each person's written confidentiality statement for Company's inspection for a period of six (6) years following termination of the Agreement.

E. ***Background Check.*** Before a member of the workforce may access Company PHI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Vendor shall retain each workforce member's background check documentation for a period of three (3) years following termination of the Agreement.

F. ***Security Officer Designation.*** Vendor shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with Company.

2. Technical Security Controls

A. ***Workstation/Laptop encryption.*** All workstations and laptops that process and/or store Company PHI must be encrypted using a FIPS 140-2 certified algorithm which is 128 bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the Company.

B. ***Server Security.*** Servers containing unencrypted Company PHI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. ***Minimum Necessary.*** Only the minimum necessary amount of Company PHI required to perform necessary business functions may be copied, downloaded, or exported.

D. ***Removable media devices.*** All electronic files that contain Company PHI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, Blackberry, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128 bit or higher, such as AES.

E. ***Antivirus software.*** All workstations, laptops and other systems that process and/or store Company PHI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. ***Patch Management.*** All workstations, laptops and other systems that process and/or store Company PHI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within thirty (30) days of vendor release.

G. ***User IDs and Password Controls.*** All users must be issued a unique user name for accessing Company PHI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within twenty-four (24) hours. Passwords are not to be shared. Passwords must be at least eight (8) characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every ninety (90) days, preferably every sixty (60) days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

   - Upper case letters (A-Z)
   - Lower case letters (a-z)
   - Arabic numerals (0-9)
   - Non-alphanumeric characters (punctuation symbols)

H. ***Data Destruction.*** When no longer needed, all Company PHI must be wiped using the Gutmann or US Department of Defense (DOD) 5220.22M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of Company.

I. ***System Timeout.*** The system providing access to Company PHI must provide an automatic timeout, requiring re-authentication of the user session after no more than twenty (20) minutes of inactivity.

J. ***Warning Banners.*** All systems providing access to Company PHI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. ***System Logging.*** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for Company PHI, or which alters Company PHI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If Company PHI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least three (3) years after occurrence.

L. ***Access Controls.*** The system providing access to Company PHI must use role based access controls for all user authentications, enforcing the principle of least privilege.

M. ***Transmission encryption.*** All data transmissions of Company PHI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128 bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI in motion such as website access, file transfer, and E-Mail.

N. ***Intrusion Detection.*** All systems involved in accessing, holding, transporting, and protecting Company PHI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

3. **Audit Controls**

A. ***System Security Review.*** All systems processing and/or storing Company PHI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. ***Log Reviews.*** All systems processing and/or storing Company PHI must have a routine procedure in place to review system logs for unauthorized access.

C. ***Change Control.*** All systems processing and/or storing Company PHI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

4. **Business Continuity / Disaster Recovery Controls**

A. ***Emergency Mode Operation Plan.*** Vendor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic Company PHI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under the Agreement for more than twenty-for (24) hours.

B. ***Data Backup Plan.*** Vendor must have established documented procedures to backup Company PHI to maintain retrievable exact copies of Company PHI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore Company PHI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of Company data.

5. **Paper Document Controls**

A. ***Supervision of Data.*** Company PHI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. Company PHI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

B. ***Escorting Visitors.*** Visitors to areas where Company PHI is contained shall be escorted and Company PHI shall be kept out of sight while visitors are in the area.

C. ***Confidential Destruction.*** Company PHI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. ***Removal of Data.*** Company PHI must not be removed from the premises of Vendor except with express written permission of Company.

E. ***Faxing.*** Faxes containing Company PHI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. ***Mailing.*** Mailings of Company PHI shall be sealed and secured from damage or inappropriate viewing of PHI to the extent possible. Mailings which include five hundred (500) or more individually identifiable records of Company PHI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of Company to use another method is obtained.

Exhibit B-16

Maryland Medicaid Compliance Addendum

This Maryland Medicaid Compliance Addendum ("Addendum") is incorporated by reference into the Agreement and applies to Medicaid products covered by the State Contract. Company and Provider agree that their duties and responsibilities under the Agreement, with respect to the Company's Maryland Medicaid operations, are modified as set forth in this Addendum. 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 Addendum, the term "Provider" shall mean the health care provider, physician, group, facility or hospital executing the Agreement, as identified on the first page of the Agreement.

Capitalized terms used and not otherwise defined in this Addendum shall have the meanings set forth in the Agreement, or, if not defined in the Agreement, in the State Contract or under State law.

I. PROVIDER MANUAL

Company shall develop and make available to Provider, either electronically or by hard copy, a Medicaid requirements manual ("Provider Manual") referencing the policies and procedures established by the Company and applicable to Providers in accordance with applicable law and Medicaid program requirements including, without limitation, utilization review, quality assurance, access, referrals, provider grievances, appeals and such other policies and procedures necessary to effect the delivery of Covered Services and facilitate Providers' compliance with federal and State Medicaid requirements. Provider shall comply with the Provider Manual and perform all services under the Agreement in a manner that is consistent with Company's Policies. [COMAR 10.09.66.04]

II. MARYLAND MEDICAID PROGRAM REQUIREMENTS

1. Incorporation by Reference. Provider is subject to all of the requirements to which Company is subject under its contract with the Maryland Department of Health and Mental Hygiene ("the Department") and pursuant to the Department's regulations. [COMAR 10.09.65.17A(5)(a)]

2. Covered Services. Provider shall provide all health benefit services that are Covered Services under the Maryland Medicaid Program in which the Company participates and which are applicable to the Maryland Medicaid Member at issue and which are within the scope of Provider's license. [COMAR 10.09.65.17A(5)(b)]

3. Release of Records to Company and the Department. Upon request, Provider shall release to Company and to the Department any information necessary for Company to perform any of its contractual and regulatory obligations under its contract with the Department, including, but not limited to, its records, reporting, and quality assurance duties. [COMAR 10.09.65.17A(5)(c)]

4. Books and Records; Government Audits and Inspection. Provider's facilities and records shall be open to inspection by Company, the Department, and other government agencies. Provider is subject to all audits and inspections to the same extent that audits and inspections may be required of Company under law or under its contract with the Department. [COMAR 10.09.65.17A(5)(d)]

5. Transfer of Member Records Upon Termination of Agreement. If the Agreement is terminated, Provider shall, upon request, provide Members' medical records to Company for transfer to a subsequent provider in the event of a termination of the Agreement. [COMAR 10.09.65.17A(5)(e)]

6. Written Notice to the Department of Termination. No termination of the Agreement shall be effective without prior written notice to the Department. [COMAR 10.09.65.17A(5)(f)]

7. Member Hold Harmless. Provider agrees to look solely to Company for compensation for Covered Services provide to Company's Members under the Agreement, except for Copayments or any other charges as set forth in the Provider Manual or permitted by the Plan. [COMAR 10.09.65.17A(5)(g)]

8. Evidence of Professional Liability Coverage. At least annually, Provider shall submit to Company evidence of Provider's professional liability coverage. [COMAR 10.09.65.17A(5)(h)]

9. Assignment. No assignment of the Agreement by Provider is effective without prior written notice to the Department. [COMAR 10.09.65.17A(5)(i)]

10. Uniform Consultation Referral Form. If authorized to make referrals, Provider, when referring the Members, shall use the uniform consultation referral form adopted by the Maryland Insurance Administration available at COMAR 31.10.12.06. [COMAR 10.09.65.17A(5)(j)]

11. Required Regulatory Provisions Controlling. Each provision in this Addendum required by COMAR 10.09.65.17A(5) supersedes and is controlling over any conflicting terms that appear in the Agreement. [COMAR 10.09.65.17A(5)(k)]

12. Representation Regarding Crimes and Sanctions under Social Security Act. Provider hereby represents and warrants that neither it nor any of its Participating Providers has been convicted of certain crimes or received certain sanctions as specified in Section 1128 of the Social Security Act. [COMAR 10.09.65.17A(4)]

13. Provider Selection. Company shall credential and re-credential Providers according to Company's documented process and shall follow the credentialing and re-credentialing policies established by the Department for managed care organizations. Company shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. [COMAR 10.09.65.17A(5) and 42 CFR 438.214]

14. Disclosure of Information Related to Business Transactions. Provider agrees to provide information necessary for Company to comply with federal regulatory requirements including any applicable requirements under 42 CFR 455.105. [COMAR 10.09.65.17A(5)]

15. Compliance with Fixed Price Contracting Regulation. If Provider is a hospital or an entity related to a hospital, Provider hereby represents and warrants that Provider is in compliance with COMAR 10.37.12.02 (i.e., fixed price contracting regulation). [COMAR 10.09.65.17A(6)]

16. Referral Records. If Provider is a Primary Care Provider, then Provider shall maintain records of referral arrangements, and the feedback and outcomes of those referrals, within each Member's medical records. [COMAR 10.09.66.05B(3)]

17. Hospital Emergency Facility and Providers. Company shall reimburse a hospital emergency facility and provider, which is not required to obtain authorization or approval for payment from Company in order to obtain reimbursement, for: (a) Emergency Services that are provided in a hospital emergency facility after the sudden onset of an Emergency Medical Condition; (b) The medical screening services that meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act; (c) Medically Necessary services which the Company authorized, referred, or instructed the enrollee to be treated at the emergency facility and the Medically Necessary services that relate to the condition which presented when the Member was allowed to use the emergency room facility; and (d) Medically Necessary services that relate to the

condition presented and that are provided by the provider in an emergency facility to the Member, if Company fails to provide 24-hour access to a physician. [COMAR 10.09.65.20B]

18. Hospital Provider Compensation. Notwithstanding any provision in the Agreement to the contrary, Company shall pay Maryland hospital providers on the basis of rates approved by the Maryland Health Services Cost Review Commission (HSCRC). [COMAR 10.09.65.02G(4)]

Regulatory Compliance Addendum

Regulatory Compliance Addendum
Governing West Virginia Medicaid Services

This Regulatory Compliance Addendum Governing West Virginia Medicaid Services (the "West Virginia Medicaid Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under the *Purchase of Service Provider Agreement Between State of West Virginia Department of Health and Human Resources Bureau for Medical Services and Coventry Health Care of West Virginia, Inc. d/b/a Aetna Better Health of West Virginia* (the "State Contract"), under which contract Coventry Health Care of West Virginia, Inc. d/b/a Aetna Better Health of West Virginia (the "Company") serves as a managed-care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract.

The State of West Virginia, its Department of Health and Human Resources, and/or its Bureau for Medical Services (collectively, the "State") require that specific terms and conditions be incorporated into the Agreement. As such, this West Virginia Medicaid Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof), and such provider, vendor, contractor, or other entity must comply with the requirements set forth herein. Note that this West Virginia Medicaid Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in the policies, procedures, and provider manual of Company (or its Affiliate, as the case may be). This West Virginia Medicaid Addendum and the Agreement may be revised as directed by the State.

For purposes of this West Virginia Medicaid Addendum, the individuals who are enrolled with Company under the State Contract will be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this West Virginia Medicaid Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this West Virginia Medicaid Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this West Virginia Medicaid Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contract and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract. Except as provided herein, all other provisions of the Agreement not inconsistent with this West Virginia Medicaid Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this West Virginia Medicaid Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The provider, vendor, contractor, or other entity identified on the first page of the Agreement acknowledges and agrees that all provisions of this West Virginia Medicaid Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members who are eligible and covered under the State Contract, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the State Contract, and it/they represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this West Virginia Medicaid Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

A. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this West Virginia Medicaid Addendum:

1. "Provider" – an individual or entity that is engaged in the delivery of health services, or ordering or referring for those services, who meets the requirements of the West Virginia Medicaid program and is a member

of Company's network. [State Contract, Article II § 1]

2. "Subcontract" – any written agreement between Company and another party to fulfill any requirements of the State Contract. [State Contract, Article II § 1]

3. "Subcontractor" – any party contracting with Company to perform any services related to the requirements of the State Contract, including without limitation affiliates, subsidiaries, and affiliated and unaffiliated third parties. [State Contract, Article II § 1]

B. Requirements Applicable to Provider/Subcontractor Contracts and Services

1. Provision of Covered Services. Provider/Subcontractor agrees to provide Covered Services to Members as set forth in the Agreement and in compliance with all applicable provider requirements specified by the State Medicaid program, including without limitation the following:

a. If a Member requires emergency medical services: (i) Provider/Subcontractor shall provide such services on a 24 hour per day, 7 day per week basis, or else will immediately refer the Member to an emergency facility; and (ii) will notify the Member's primary care provider (PCP) of the Member's screening and treatment within 10 calendar days of presentation for such emergency services. Provider/Subcontractor will provide urgent care services within 48 hours of request. [State Contract, Article III §§ 1.2.2, 2.1.2, 2.7.5]

b. If a Member requires routine care, other than clinical preventive services, Provider/Subcontractor shall provide such services within 21 days of request. [State Contract, Article III § 2.1.2]

c. If a Member requires Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, Provider/Subcontractor shall schedule those services in accordance with applicable EPSDT guidelines and the EPSDT Periodicity Schedule for Members under the age of 21. [State Contract, Article III § 2.1.2]

d. If a Member requires prenatal care, Provider/Subcontractor shall schedule the initial prenatal care visit within 14 days of the date on which the woman is found to be pregnant. [State Contract, Article III § 2.1.2]

e. If a Member requires specialty care, including women's health services, Provider/Subcontractor shall take the Member's input into consideration as part of any proposed treatment plan. [State Contract, Article III § 2.1.3]

f. If Provider/Subcontractor is a primary care provider (PCP), Provider/Subcontractor shall (i) provide 24-hour access and physician coverage for Members; (ii) maintain continuity of each Member's healthcare; (iii) make referrals, as needed, for specialty care and other medically necessary services, including dental referrals as part of the EPSDT process, consistent with Company's utilization-management policies; (iv) maintain a current medical record for the Member, including documentation of all services provided to the Member, as well as any specialty or referral services; (v) adhere to the EPSDT Periodicity Schedule for Members under the age of 21; (vi) follow Company-established procedures for coordination of in-network and out-of-network services for Members, and serve as the coordination-of-care manager for the Member's overall care; (vii) identify and refer Members, as needed, to behavioral-health providers; and (viii) cooperate with Company with respect to Company's obligation under the State Contract to monitor PCP actions to ensure compliance with Company and State Medicaid program policies. [State Contract, Article III §§ 2.1.2, 2.2.1, 5.6.1, 9.5, 10.5]

g. Provider/Subcontractor shall ensure that its EMTALA obligations are fulfilled as required by law and by the State Contract, and shall not create any conflicts with any hospital actions required to comply with EMTALA. [State Contract, Article III § 1.2.2]

h. Provider/Subcontractor shall maintain convenient hours of operation that do not discriminate against Members and that are no less than the hours of operation offered to commercial enrollees or to comparable Medicaid fee-for-service enrollees. Provider/Subcontractor shall also ensure that waiting times at sites of care are kept to a minimum and that the waiting-time standard for Members is the same standard used for commercial enrollees. Furthermore, Provider/Subcontractor shall not discriminate against Members in the order that patients are seen or that appointments are given. [State Contract, Article III § 2.1.2]

i. Provider/Subcontractor shall not segregate Members in any manner from other persons receiving services, and furthermore shall not, based on the Members' status as Medicaid recipients: (i) deny or refuse to provide Covered Services or facility access to Members; (ii) provide to Members any Covered Services that are different, or that are provided in a different manner or at a different time, from that provided to other enrollees, to other public or private patients, or to the public at large; (iii) subject Members to segregation or separate treatment in any manner related to the receipt of any Covered Service; or (iv) assign times or places for the provision of services to Members on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, program membership, or physical or mental disability. [State Contract, Article III § 2.5]

j. Provider/Subcontractor shall ensure that its facilities are readily accessible to and usable by Members with physical and mental disabilities (with Provider/Subcontractor making reasonable accommodations and providing accessible equipment for those disability Members), and that auxiliary aids and services are provided to ensure effective communication, all in compliance with Title III of the Americans with Disabilities Act of 1990, as amended. [State Contract, Article III §§ 2.1.2, 3.7.4]

k. If Provider/Subcontractor is a primary care provider (PCP): (i) it shall not close its panel to Members or Medicaid enrollees alone (*i.e.*, if a PCP's panel is closed, it must be closed to all enrollees); and (ii) if its panel later reopens, it shall admit patients on a first-come, first-served basis (provided, however, that if it already has the maximum of 2,000 Medicaid enrollees, it may admit additional, non-Medicaid patients). [State Contract, Article III § 2.5]

l. Provider/Subcontractor shall provide Covered Services in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, those who are homeless, and those with physical and mental disabilities. [State Contract, Article III §§ 2.1.2, 3.7.3]

m. When providing Covered Services to a Member, Provider/Subcontractor shall take into consideration and act in accordance with the Member rights enumerated in Section 3.6 ("Enrollee Rights") of Article III of the State Contract, and shall cooperate with Company with respect to Company's obligation under the State Contract to monitor Provider/Subcontractor actions to ensure compliance with those Member rights. [State Contract, Article III § 3.6]

2. Claims; Payment. Provider/Subcontractor acknowledges and agrees that Company's payment of claims for Covered Services rendered to Members is subject to the provisions and requirements set forth in the Agreement and State Contract (including Section 2.7 of Article III thereof), and Provider/Subcontractor furthermore agrees as follows:

a. Provider/Subcontractor acknowledges and agrees that with respect to any Covered Services, Company shall be prohibited from paying for any item or service that is: (i) furnished by any individual or entity during any period when that individual or entity is excluded from participation under Titles V, XVIII, or XX of the Social Security Act or sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act; (ii) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX or sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); (iii) furnished by an individual or entity with respect to which the State has determined that there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23, unless the State has good cause not to suspend such payments; (iv) with respect to any amount expended for which

funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (v) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Medicaid plan; or (vi) for home health care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in section 1861(o)(7) of the Social Security Act. [State Contract, Article II § 8.6.1 and Article III § 8.2; 42 C.F.R. § 455.23]

b. Provider/Subcontractor acknowledges and agrees that Company shall not pay Provider/Subcontractor, and if Provider/Subcontractor has engaged a downstream provider, that Provider/Subcontractor shall not pay such downstream provider, for any provider-preventable condition (PPC), health care-acquired condition (HCAC), or other provider-preventable condition (OPPC) that meets the definitions thereof under section 2702 of the Patient Protection and Affordable Care Act of 2010. Such conditions include conditions not present on hospital admission, wrong surgical or other invasive procedures performed on a patient, surgical or other invasive procedures performed on the wrong body part, and/or surgical or other invasive procedures performed on the wrong patient. In accordance and compliance with 42 C.F.R. § 447.26(d), Provider/Subcontractor shall report all provider-preventable conditions associated with claims for payment or Member treatments for which payment would otherwise be made, and if Provider/Subcontractor has engaged a downstream provider, shall similarly require such downstream provider to report all provider-preventable conditions associated with claims for payment or Member treatments for which payment would otherwise be made, as a condition of payment. [State Contract, Article III §§ 2.6.3, 2.7.8]

c. Unless Provider/Subcontractor has agreed to a later payment in writing, Company shall pay all Clean Claims (as that term is defined below) within 30 days of receipt for medically necessary Covered Services that Provider/Subcontractor has provided to Members, when such Covered Services (i) were rendered to treat a medical emergency, (ii) were rendered in accordance with the terms of the Agreement, or (iii) were prior authorized. If Provider/Subcontractor, in turn, is responsible for paying a downstream provider of Provider/Subcontractor, then Provider/Subcontractor shall pay any in-network downstream provider all Clean Claims (as that term is defined below) within 30 days of receipt (unless such downstream provider has agreed to a later payment from Provider/Subcontractor in writing) for medically necessary Covered Services that such downstream provider of Provider/Subcontractor has provided to Members, when such Covered Services (i) were rendered to treat a medical emergency, (ii) were rendered in accordance with the terms of the agreement between Provider/Subcontractor and its downstream provider, or (iii) were prior authorized. Company must pay Provider/Subcontractor interest at 7% per annum, calculated daily, for the full period during which any Clean Claim remains unpaid beyond the 30-day deadline for payment of Clean Claims; such interest must be paid to Provider/Subcontractor on the same date on which the claim is paid. For purposes of this provision, the term "Clean Claim" means a bill for services, a line item of service, or all services for one Member within a bill that can be processed without obtaining additional information from the provider of such services or from a third-party, but does not include any claim that is under review for medical necessity or that has been submitted by a person or entity that is under investigation for fraud or abuse. [State Contract, Article III §§ 2.6.3, 2.7.1, 2.7.2, 2.7.7]

d. Company shall accept claims from Provider/Subcontractor in either electronic or paper form. Company shall specify (i) the date of claim receipt as the date on which Company receives the claim, as indicated on the date stamp on the claim or other notation as appropriate to the medium used to file a claim, and (ii) the date of claim payment as the date of the check release or other form of payment release to Provider/Subcontractor. [State Contract, Article III §§ 2.7.1, 2.7.7]

3. No Billing of Members; Hold Harmless. With respect to Provider/Subcontractor's provision of Covered Services to Members under the Agreement:

a. Provider/Subcontractor shall not directly receive payment or any type of compensation from Members for providing Covered Services. Provider/Subcontractor may not bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or any persons acting on their behalf, for services rendered in accordance with the Agreement. This prohibition applies even if Company becomes insolvent, fails to pay Provider/Subcontractor for services rendered, or otherwise breaches the Agreement; in each case Company, rather than the Members, shall remain liable for any amounts that remain unpaid to Provider/Subcontractor for services rendered under the

Agreement, and Provider/Subcontractor shall hold the Members, the State, and the State's officers and employees harmless from any debts of Company. This prohibition similarly applies if Provider/Subcontractor engages any downstream providers or subcontractors and thereafter becomes insolvent, fails to pay those downstream entities for services rendered, or otherwise breaches its agreement with those downstream entities; in each case Provider/Subcontractor, rather than the Members, shall remain liable for any amounts that remain unpaid by Provider/Subcontractor for services rendered under its agreement with its downstream entities, and Provider/Subcontractor's downstream entities shall hold the Members, the State, and the State's officers and employees harmless from any debts of Provider/Subcontractor. The State shall not be liable or responsible for payment of any Covered Services rendered under the Agreement, or under any agreement that Provider/Subcontractor has with its downstream providers or subcontractors. If at any time during the provision of services under the Agreement, Provider/Subcontractor or its agents are aware that the Member is an enrollee of Company, neither that Provider/Subcontractor nor any representative/agent thereof may (i) collect or attempt to collect from that Member any money for services covered by Company, or (ii) maintain any action at law against that Member to collect any money that Company owes to that Provider/Subcontractor. If Provider/Subcontractor violates this paragraph of the West Virginia Medicaid Addendum, the State Insurance Commissioner may impose a civil monetary penalty against Provider/Subcontractor. Notwithstanding the foregoing, this paragraph of the West Virginia Medicaid Addendum does not prohibit the collection from Members of State-authorized co-payments for providing Covered Services. [W. Va. Code §§ 33-25A-7a(1)–(5), 33-25A-14a(b), 33-25A-23a; State Contract, Article III §§ 2.6.3, 7.1, 7.6]

b. Provider/Subcontractor shall not bill or collect any payment from Members for care that was determined not to be medically necessary. Furthermore, if Provider/Subcontractor knowingly and willfully charges a Member for any service provided to that Member under the State Contract at a rate in excess of the rates established by the State or under the State Contract, Provider/Subcontractor may be guilty of a felony and upon conviction may be fined no more than $25,000 or imprisoned for no more than five years, or both. [State Contract, Article III § 1.5]

c. *No Charges*. Provider/Subcontractor shall hold harmless and not impose any charges on Members for benefits provided under the State Contract and shall regard Company's payment as payment in full for all benefits covered by this Agreement, with the exception of co-payments specifically authorized in the State Contract or otherwise by the State, and any amounts due for services that are not Covered Services under the State Contract. Provider/Subcontractor shall also be entitled to receive payment for third-party claims. Provider/Subcontractor will never, under any circumstances, including non-payment by Company, the insolvency of Company, or breach or termination of this Agreement, seek compensation from, have any recourse against, or impose any additional charge on any Member for benefits provided under the State Contract. Provider/Subcontractor shall look only to Company for payment for benefits provided under the State Contract. If Company receives notice that Provider/Subcontractor has billed or collected from a Member for any Covered Services or non-authorized benefits, Company may refund that amount to Member and may offset that amount from any payment to Provider/Subcontractor, with prior notice to the Provider/Subcontractor.

d. *No Collection Action Against Members*. Neither Provider/Subcontractor, nor any trustees or assignees thereof, may maintain any action at law against a Member to collect sums owed by Company.

e. *Collection of Copayments*. The provisions in this paragraph of the West Virginia Medicaid Addendum ("No Billing of Members; Hold Harmless") shall not preclude Provider/Subcontractor from collecting the copayments that are specifically authorized by the State Contract or otherwise by the State.

f. *Non-Covered Services*. A Provider/Subcontractor may bill a Member for services if: (i) prior to receiving such services the Member is advised that such services are not Covered Services; and (ii) after being advised of same and of the cost thereof, the Member nevertheless elects in writing to receive such non-Covered Services.

g. *State Hold Harmless*. Company shall indemnify, defend, and hold harmless, and Provider/Subcontractor and its downstream providers and subcontractors (if any) shall hold harmless, the

State and its officers and employees from: (i) any claims or losses for services rendered by Provider/Subcontractor and/or its downstream providers or subcontractors (if any), or by any other person or firm performing or supplying services, materials, or supplies in connection with the performance of the State Contract; (ii) any claims or losses to any person or firm injured or damaged by the erroneous or negligent acts, including without limitation disregard of federal or State Medicaid statutes or regulations, of Provider/Subcontractor and/or its downstream providers or subcontractors (if any) in the performance of any services relating to the State Contract; (iii) any claims or losses resulting to any person or entity injured or damaged by Provider/Subcontractor and/or its downstream providers or subcontractors (if any) by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used in connection with the State Contract in a manner not authorized by the State Contract or by federal or State statutes or regulations; and (iv) any failure of Provider/Subcontractor and/or its downstream providers or subcontractors (if any) to observe State and federal laws, including but not limited to labor and minimum wage laws.

h. *Survival of Covenants*. Provider/Subcontractor further agrees that the provisions in this paragraph of the West Virginia Medicaid Addendum ("No Billing of Members; Hold Harmless") shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member and the State, and that these provisions supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider/Subcontractor and Member or any persons acting on their respective behalf.

[W. Va. Code § 33-25A-7a(1)–(5); State Contract, Article II § 5.6 and Article III §§ 2.6.3, 7.1]

4. Member Copayments & Cost-Sharing Obligations. With respect to Provider/Subcontractor's collection of Member copayments:

a. Provider/Subcontractor is prohibited from collecting copayments from the Member for missed appointments. [State Contract, Article III § 2.6.3]

b. If Provider/Subcontractor is a provider of emergency care, Provider/Subcontractor shall inform Members of the copayment amount for any non-emergency services provided in an emergency department prior to providing such non-emergency services, and shall furthermore provide Members with the name and location of an available and accessible alternative non-emergency services provider. [State Contract, Article III §§ 2.6.3, 3.9]

c. Provider/Subcontractor shall impose Member copayments for Covered Services in the amounts determined by the State in accordance with the requirements specified in the State Medicaid Plan and the requirements of 42 C.F.R. §§ 447.50–447.82. Provider/Subcontractor acknowledges and agrees that the State Contract requires a reduction of the payment made to the provider of Covered Services by the amount of the Member's copayment, regardless of whether the copayment is successfully collected. Neither the Provider/Subcontractor nor its downstream providers (if applicable) shall routinely waive required Member copayments. [State Contract, Article III § 3.9]

d. Provider/Subcontractor shall charge copayments to the following Members and on the following Covered Services: (i) inpatient and outpatient services; (ii) physician office visits, including without limitation office visits to a nurse practitioner; (iii) non-emergency use of an emergency department; (iv) caretaker relatives age 21 and over; (v) transitional Medicaid members age 21 and over; and (vi) any other Members identified by Contractor that are not specifically exempt. [State Contract, Article III § 3.9.2]

e. Notwithstanding the foregoing, neither Provider/Subcontractor nor its downstream providers (if applicable) shall charge copayments to the following Members or with respect to the following Covered Services: (i) family-planning services; (ii) emergency services; (iii) pregnancy-related services; (iv) services furnished to women who are receiving medical assistance on the basis of the breast- or cervical-cancer eligibility group; (v) preventative services for Members under the age of 18; (vi) services for provider-preventable conditions; (vii) Members under the age of 21; (viii) pregnant Members (including the 60-day postpartum period following the end of pregnancy); (ix) American Indians and Alaska Natives;

(x) Members receiving hospice care; (xi) Members in nursing homes; (xii) behavioral-health services; (xiii) any additional Members or services excluded under the State Medicaid Plan; and (xiv) Members who have met their household maximum limit for the cost-sharing obligations per calendar quarter. Furthermore, Provider/Subcontractor shall not charge copayments with respect to "Value-Added Services" (as that term is defined in Section 1 of Article II of the State Contract and used in Section 3.10 of Article III of the State Contract) that it may provide to Members covered under the State Contract. Finally, Members who have primary insurance other than Medicaid are exempt from Medicaid cost-sharing obligations. When a third party has made a payment for a Covered Service and Company is the secondary payer, the Medicaid-allowed amount shall be calculated as the difference between the paid amount and the Medicaid-allowed amount compared to the sum of the co-insurance, copayment, and deductible amounts. Company is responsible for paying the lesser of either the difference amount or the summed amount. [State Contract, Article II § 1 and Article III §§ 3.9.1, 3.9.3, 3.10]

5. Offshore Services. Provider/Subcontractor is prohibited from engaging or paying any individual or entity (an "Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative, or other individual or entity) to perform any services for Company in connection with the State Contract 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/Subcontractor further agrees that Company has the right to audit any Offshore Entity prior to the provision of Offshore Services for Company. Provider/Subcontractor further represents and warrants that it does not and will not permit any Member's protected health information (PHI), or any other information that Company or a Provider or Subcontractor has obtained in connection with the State Contract, to be accessible by any Offshore Entity without prior written notice to Company and without Company's prior written approval of such Offshore Entity. In the event that Company agrees in advance and in writing to permit Provider/Subcontractor to engage, pay, and/or send any information to an Offshore Entity to perform any services for Company in connection with the State Contract, Provider/Subcontractor agrees that the Offshore Entity and the related Offshore Services may be subject to mandatory reporting to CMS and/or other applicable government regulators. [State Contract, Article II § 5.22]

6. State Review, Approval, and Modification. Provider/Subcontractor acknowledges and agrees that the Agreement is subject to State review and that the State Insurance Commissioner has the power to require immediate cancellation or renegotiation of the Agreement if the Commissioner determines that the Agreement provides for excessive payments, fails to include reasonable incentives for cost control, or otherwise substantially and unreasonably contributes to escalation of the costs of providing health care services to Members. Furthermore, Provider/Subcontractor acknowledges and agrees that the State has the right (a) to disallow a proposed contractual arrangement between Company and Provider/Subcontractor if Provider/Subcontractor has been formally restricted from participating in a federal entitlement program (*e.g.*, Medicare or Medicaid), (b) to object to the selection of a Provider/Subcontractor, and/or (c) to require the replacement of, or implementation of a corrective action plan with respect to, any Subcontractor that the State has found to be unacceptable or unable to meet the requirements of the State Contract. [W. Va. Code § 33-25A-7(c); State Contract, Article II § 8.4]

7. Family-Planning Services. To the extent that Provider/Subcontractor provides family-planning services under the Agreement, Company reserves the right to require Provider/Subcontractor to submit claims and/or reports in specified formats before reimbursing for such family-planning services. Furthermore, any Provider/Subcontractor that provides cost, quality, or medical-appropriateness reviews, or that provides coordination-of-benefits or subrogation services, must keep family-planning information and records (including any information and records received from non-participating providers) confidential in favor of the individual patient, even if that patient is a minor. [State Contract, Article III § 1.2.4]

8. Member Identification & Eligibility. Upon its Members' enrollment and/or reenrollment with Company, Company shall provide Members with an identification card as a means to identify themselves to Provider/Subcontractor as a Medicaid-eligible enrollee of Company. Prior to Company's issuance of that Member identification card, the separate Medicaid identification card issued by the State will serve as the Member's identification card. Provider/Subcontractor must ask to see both the State's Medicaid identification card and Company's Member identification card to verify the Member's eligibility and enrollment. [State Contract, Article III § 3.4.2]

9. Information for Provider Directory. Upon Company's request, Provider/Subcontractor shall provide the following information to Company: (a) Provider/Subcontractor's name, location(s), telephone number(s), and website URLs (as appropriate); (b) any languages other than English spoken by Provider/Subcontractor, and whether Provider/Subcontractor has completed cultural competence training; (c) whether Provider/Subcontractor is accepting new patients; (d) Provider/Subcontractor's provider group affiliations and provider specialties (as appropriate); and (e) whether Provider/Subcontractor has office accommodations for people with physical disabilities (including offices, exam room(s), and equipment). [State Contract, Article III § 3.4.4]

10. Encounter Data and Other Reporting Obligations. Provider/Subcontractor shall submit accurate and complete encounter records in such manner, format, and certification, and pursuant to such timeframes, as requested by Company so as to permit Company to meet its encounter-reporting obligations under the State Contract. Furthermore, Provider/Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor Provider/Subcontractor to ensure that Provider/Subcontractor's encounter data are accurate, complete, and timely submitted. To the extent that Provider/Subcontractor directly furnishes services to Members, Provider/Subcontractor shall comply with all applicable State reporting requirements related to those services. [State Contract, Article III §§ 5.11, 5.11.4, 6.5]

11. Reporting of Required Reportable Diseases. Provider/Subcontractor shall comply with all State requirements related to the mandatory reporting of certain infectious diseases, including sexually transmitted diseases (STDs), tuberculosis, and other communicable diseases. [State Contract, Article III § 5.11.9]

12. Subcontracts. With respect to any and all Subcontracts:

a. Subcontractor does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and does not permit its employees to perform their services at any location under Subcontractor's control where segregated facilities are maintained; Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to provide to the State or other applicable authorities a copy of a certification attesting to same. The breach of this certification is a violation of Equal Opportunity in federal employment. In addition, Company and Subcontractor must comply with the Federal Executive Order 11246 entitled "Equal Employment Opportunity" as amended by Executive Order 11375 and as supplemented in the United States Department of Labor Regulations (41 C.F.R. Part 30). As used herein, the term "segregated facilities" includes any waiting rooms, restaurants and other eating areas, parking lots, drinking fountains, recreation or entertainment areas, transportation, and housing facilities provided for employees which are segregated on the basis of race, color, religion, or national origin, because of habit, local custom, national origin, or otherwise. [State Contract, Article II § 5.3]

b. Subcontractor must act in an independent capacity and must not hold itself out to be an officer or employee of the State in connection with the State Contract. [State Contract, Article II § 5.8]

c. If Subcontractor seeks to terminate its Subcontract with Company for any reason, Subcontractor must provide to Company a written notice of Subcontractor's intent to terminate within the following timeframes: (i) within 90 days prior to the termination date of the Subcontract for systems operations or reporting; (ii) within 30 days prior to the termination date of the Subcontract for administrative services; and (iii) within 30 days prior to the termination date of any other Subcontract. [State Contract, Article II § 8.4]

d. If Company delegates to Subcontractor the performance of any duties for which Company is responsible under the State Contract, Subcontractor shall perform such delegated duties to the same extent and under the same requirements as if performed directly by Company. Subcontractor shall comply with all provisions of the State Contract that relate to the services or activities that Company has delegated to Subcontractor under the Agreement. [State Contract, Article II § 8.4 and Article III § 11]

e. If Company delegates to Subcontractor the performance of any duties relating to operation of a call center, Subcontractor's call center must meet or exceed the phone-line performance

standards set forth in the State Contract (and in particular Section 2.6.1 of Article III thereof). [State Contract, Article III § 2.6.1]

f. If Company delegates to Subcontractor the selection of Providers under the Agreement, Company shall retain the right to approve, suspend, or terminate any Provider selected by that Subcontractor. [State Contract, Article III § 11]

g. If Company delegates to Subcontractor any credentialing or recredentialing activities/obligations, Subcontractor shall conduct such activities/obligations in compliance with all applicable credentialing/recredentialing standards and requirements set forth in the State Contract (and in particular Section 2.1 of Article III thereof) and in applicable federal and State laws, regulations, and written policies. [State Contract, Article III §§ 2.1.4, 2.1.5, 2.1.6]

h. If Company delegates to Subcontractor any activities or obligations of Company under the State Contract: (i) Subcontractor acknowledges and agrees that prior to such delegation, Company shall be entitled and obligated to evaluate Subcontractor's ability to perform such delegated functions; and (ii) Company may revoke such delegation or impose other sanctions if the Subcontractor's performance is inadequate, all in accordance with the terms set forth in the Agreement. [State Contract, Article III § 11]

i. Subcontractor acknowledges and agrees that Company is entitled and obligated to monitor Subcontractor's performance on an ongoing basis consistent with 42 C.F.R. § 438.230. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor Subcontractor's performance. [State Contract, Article II § 8.4 and Article III § 11]

j. If Company identifies deficiencies or areas for improvement in the Subcontractor's performance under the Agreement, Subcontractor shall cooperate with Company in taking all necessary corrective actions. [State Contract, Article II § 8.4 and Article III § 11]

k. The Subcontract shall be in writing and shall be agreed upon in compliance with Company's obligations under the State Contract (and to the extent that Subcontractor engages any downstream providers or subcontractors, any such downstream agreements shall be in writing and so agreed-upon as well), including without limitation any agreement under which Company receives rebates, recoupments, discounts, payments, incentives, fees, free goods, bundling arrangements, or any other consideration from Subcontractor or any other third party as related to the State Contract. The Subcontract shall not terminate the legal liability of Company under the State Contract, including without limitation any liability for damages, penalties, or disallowances imposed on the State or Company arising from any non-compliance or non-performance related to the delivery of Covered Services or other deliverables under the State Contract by Company or its Subcontractors or agents, and Company shall remain solely responsible for fulfillment of the State Contract and shall assume prime contractor responsibility under the State Contract. Furthermore, if Company delegates to Subcontractor any functions or responsibilities under the State Contract, Company shall remain accountable and liable to the State for any such functions/responsibilities, and Subcontractor shall cooperate with Company with respect to Company's obligations in this regard. [State Contract, Article II § 8.4]

l. Company shall have the right to revoke any subcontract or impose sanctions if the Subcontractor's performance is inadequate, all in accordance with the terms set forth in the Agreement. [State Contract, Article III § 8.4]

13. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy benefits under the State Contract:

a. For physician-administered drugs provided under managed care, Provider/Subcontractor shall ensure that each pharmacy and medical encounter includes a 340B indicator, supplied by the provider at the time of billing, that verifies whether or not a 340B drug was dispensed/administered to the Member. Provider/Subcontractor must report this information using a standardized template supplied by the State. [State Contract, Article III §§ 5.11.12]

14. Dental Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to dental benefits under the State Contract:

a. Provider/Subcontractor shall administer all dental benefits in accordance with the provisions and requirements of Section 9 ("MHT Children's Dental Services") of Article III of the State Contract, including without limitation all credentialing/recredentialing, licensing, reimbursement, and continuity-of-care provisions and requirements therein, and in accordance with all applicable State and federal laws and regulations. [State Contract, Article III §§ 9.1–9.7]

b. If Company delegates to Provider/Subcontractor any activities or obligations related to dental benefits under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 9 ("MHT Children's Dental Services") of Article III of the State Contract. [State Contract, Article III §§ 9.1–9.7]

c. For those Providers that induce central nervous system anesthesia, Provider shall maintain an anesthesia permit and/or certificate from the West Virginia Board of Dental Examiners. [State Contract, Article III § 2.1.6]

15. Behavioral-Health Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to behavioral-health benefits under the State Contract:

a. Provider/Subcontractor shall administer all behavioral-health benefits in accordance with the provisions and requirements of Section 10 ("Behavioral Health Services") of Article III and Appendix A ("Description of MCO Covered and Excluded Services") of the State Contract, including without limitation all licensure and service-authorization provisions and requirements therein. Provider/Subcontractor shall also administer all behavioral-health benefits in accordance with all applicable State and federal laws and regulations, including without limitation 42 C.F.R. Subpart K, Parity in Mental Health and Substance Use Disorder Benefits, and shall not impose any aggregate lifetime, annual dollar limits, or other cumulative financial limits on mental-health or substance use disorder services. [State Contract, Article III §§ 10.1–10.11]

b. If Company delegates to Provider/Subcontractor any activities or obligations related to behavioral-health benefits under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 10 ("Behavioral Health Services") of Article III of the State Contract. [State Contract, Article III §§ 10.1–10.11]

c. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract to enhance available substance use disorder prevention and treatment services available to Members, as set forth more fully in Section 10.11 ("Substance Use Disorder Services") of Article III of the State Contract. [State Contract, Article III §§ 10.11]

16. Physician Incentive Plan Requirements. In the event compensation to Provider/Subcontractor under the Agreement includes Physician Incentive Plans (PIPs) as defined by federal law, those PIPs shall comply with 42 C.F.R. §§ 417.479, 422.208, 422.210, and 438.6(h) (as they may be amended from time to time and/or any successor regulations thereto). Company, as applicable, shall make no specific payment directly or indirectly under a PIP to Provider/Subcontractor as an inducement to reduce or limit medically necessary Covered Services furnished to a Member. PIPs shall not contain provisions that provide incentives, monetary or otherwise, for the withholding of medically necessary care. Provider/Subcontractor further acknowledges and agrees that in the event Provider/Subcontractor is deemed to be at substantial financial risk under applicable PIP regulations, Provider/Subcontractor shall (i) cooperate and assist Company in conducting satisfaction surveys of Members who have used Provider/Subcontractor's services and in fulfilling Company's PIP-related reporting obligations under the State Contract; and (ii) obtain, at Provider/Subcontractor's sole expense, any additional stop loss insurance required pursuant to the PIP regulations. [State Contract, Article III § 2.8]

17. Quality Assessment/Performance Improvement (QAPI) Program. Provider/Subcontractor shall participate in Company's quality assessment/performance improvement program (QAPI) activities, shall cooperate with Company with respect to Company's QAPI obligations under the State Contract, and shall cooperate with

Company's quality-improvement committee. Provider/Subcontractor's QAPI participation shall include, but is not limited to, providing access to medical records, cooperation with data-collection activities, and compliance with credentialing/recredentialing of healthcare providers. [W. Va. Code § 33-25A-17a; State Contract, Article III § 6.5]

18. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services. Provider/Subcontractor shall provide EPSDT services to Members in compliance with the State Contract (and in particular Section 1.2.1 of Article III thereof), with applicable State and federal laws, regulations, and policy statements, and with applicable Company policies and procedures relating to EPSDT. Provider/Subcontractor shall cooperate with Company with respect to Company's EPSDT-related obligations under the State Contract. [State Contract, Article III § 1.2.1]

19. Third Party Liability. Provider/Subcontractor acknowledges and agrees that Medicaid payment, under the State Contract or otherwise, is secondary to other sources of payment for Covered Services provided to Members, and that Medicaid (and consequently Company, as a Medicaid MCO of the State) is the payer of last resort. Provider/Subcontractor furthermore acknowledges and agrees that when Company is aware of third-party sources of payment for Covered Services, Company is required by the State Contract to "cost avoid" (*i.e.*, deny) the associated claim and to redirect Provider/Subcontractor to bill that third-party source of payment as the primary payer. Provider/Subcontractor may not interfere with or place any liens upon the State's right or Company's right, acting as the State's agent, to recover from third-party resources. Notwithstanding the foregoing, neither Company nor Provider/Subcontractor may refuse to furnish Covered Services to Members on account of a third party's potential liability for those Covered Services. [State Contract, Article III §§ 2.6.3, 7.5]

20. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to cooperate with the State as part of any readiness review under the State Contract prior to Provider/Subcontractor's operational start date. [State Contract, Article II § 7]

b. Company's obligation to submit financial and expense-related reports/data to the State relating to the Risk Corridor Payment Adjustment and the Medical Loss Ratio (MLR) calculation set forth in the State Contract. [State Contract, Article III §§ 7.1–7.3]

c. Company's obligation to investigate, pursue, recover, and report on overpayments (including those due to fraud, waste, and abuse), and on coordination-of-benefit and third-party-liability resources and recoveries. [State Contract, Article III §§ 7.5, 8.3]

d. Company's obligation to submit reports and other data to the State as set forth in the State Contract. [State Contract, Article II §§ 4.14, 8.4 and Article III § 5.11]

e. Company's obligation to supply employment/affirmative-action information to the State, as set forth in the State Contract, for State compliance with Title VI and Title VII of the Civil Rights Act of 1964. [State Contract, Article II § 5.5]

f. Company's obligation to provide timely, substantive responses to information requests received from the State in connection with the State Contract. [State Contract, Article II § 5.12]

g. Company's obligation to maintain and keep current a Subcontractor monitoring plan and to provide a copy of such monitoring plan to the State within ten (10) business days of the State's request. [State Contract, Article II § 8.4]

h. Company's obligation to disclose to the State and/or other applicable governmental agencies the ownership-and-control and prohibited-affiliation information required under Section 8.6 of Article II of the State Contract and/or 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610. [State Contract, Article II § 8.6]

i. Company's obligation to timely communicate with the Provider/Subcontractor's emergency department (if applicable) regarding emergency Covered Services to expedite postevaluation or

poststabilization services in order to avoid material deterioration of the Member's condition. [W. Va. Code § 33-25A-8a(b)(4)]

j. Company's obligation to provide a "patient-centered medical home" for its Members. [State Contract, Article III § 1.6.1]

k. Company's obligation to develop and implement Performance Improvement Projects as set forth in the State Contract. [State Contract, Article III § 6.2]

l. Company's obligation to ensure continuity and coordination of care with respect to healthcare services provided to Members, including timely communication of clinical information among providers. [State Contract, Article III §§ 5.3, 5.6]

m. Company's obligation to investigate and report fraud, waste, and abuse, with Provider/Subcontractor reporting to Company any suspected fraud, waste, or abuse of which Provider/Subcontractor becomes aware. [State Contract, Article III § 8.1]

n. Company's obligation to respond to any deficiency/non-performance notice, notice of conditions endangering contract performance, breach/default notice, or request for a corrective action plan that Company receives from the State relating to Subcontractor or to the services that are within the scope of the Agreement. [State Contract, Article II, §§ 6.2–6.4, 8.4 and Article III § 6.3]

o. If Provider/Subcontractor is a primary care provider (PCP), Company's obligation to monitor PCP panel status and capacity. [State Contract, Article III § 2.2.7]

p. Company's provider complaint and appeal processes. [State Contract, Article III § 2.6.3]

q. Company's obligation (i) to design, develop, implement, and conduct annual provider-satisfaction surveys to evaluate provider and provider-staff satisfaction with Company, and (ii) to collect, analyze, and submit to the State the results of such provider-satisfaction surveys on an annual basis. [State Contract, Article III § 2.6.5]

r. Company's obligation to maintain a Transition Plan (as that term is defined and used in the State Contract) relating to termination or expiration of the State Contract and related documentation. [State Contract, Article II § 6.15]

21. Termination of Agreement and Effect Thereof. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the Parties. Furthermore, in the event this West Virginia Medicaid Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or product participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties. In addition, Provider must provide at least 60 days' prior written notice to Company and the State Insurance Commissioner before terminating this Agreement for any reason. Nonpayment for goods or services rendered by Provider to Company under the Agreement is not a valid reason for avoiding such 60-day advance notice of termination. Upon receipt by Company of a 60-day cancellation notice, Company may terminate the Agreement in less than 60 days if requested by Provider and if Company is not financially impaired or insolvent. [W. Va. Code § 33-25A-7a(7)–(8)]

22. Confidentiality; Protected Health Information. With respect to the confidentiality of data and records:

a. Provider/Subcontractor shall abide by the same statutes and regulations regarding the confidentiality of protected health information that Company is itself subject to under the State Contract and state and federal law, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d), the Health Information Technology for Economic and Clinical Health Act (42 U.S.C. § 17931, *et seq.*), and 45 C.F.R. Parts 160 and 164. All information that Provider/Subcontractor obtains through the services that it performs in connection with the State Contract, including without limitation information

relating to Members or other applicants or recipients of State programs (*e.g.*, medical records and data or data elements collected, maintained, or used, adolescent and/or STD appointment records, etc.) is confidential to the extent that confidential treatment is provided under state and federal law, rules, and regulations, must be protected from unauthorized disclosure, and shall only be used in a manner as is necessary for the proper discharge of obligations and securing of rights in connection with the State Contract. Provider/Subcontractor must furthermore establish procedures: (i) to develop and promulgate policies in accordance with federal and State law establishing who is authorized to receive such information; (ii) to safeguard the privacy of any information that identifies a particular Member by ensuring that information from Company or copies of records may be released only to authorized individuals, that unauthorized individuals cannot gain access to or alter patient records, and that original medical records are released only in accordance with federal or State law, court orders, or subpoenas; (iii) to address the confidentiality and privacy for minors, subject to applicable federal and State law; and (iv) to abide by all federal and State laws regarding confidentiality and disclosure for mental health records, medical records, other health information, and any information about Members. This confidentiality provision shall survive termination of the Agreement. [State Contract, Article II § 8.4 and Article III §§ 2.6.3, 5.10]

b. If Provider/Subcontractor provides cost, quality, or medical-appropriateness reviews, or coordination-of-benefits or subrogation services, it shall maintain the confidentiality of all Member medical records and shall not release that information without the written consent of the Member or other responsible party, except as specified below:

(i) Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities that are providing services to Members under a Subcontract with Company. This provision also applies to specialty providers who are retained by the Company to provide services that are infrequently used or are of an unusual nature. This also allows for transfer of information (written or verbal) to the State and its staff and subcontractors.

(ii) Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care, or to the Company, its staff, its contracted Providers, or its Subcontractors that are providing cost, quality, or medical-appropriateness reviews, or coordination-of-benefits or subrogation services.

(iii) Written consent is required for the transmission of the medical record information of a former Member to any physician not connected with Company, except as set forth in subparagraph (ii) immediately above.

The extent of medical record information to be released in each instance above will be based upon tests of medical necessity and a "need to know" basis on the part of the practitioner or facility requesting the information. [State Contract, Article III § 5.10]

23. Inspection of Facilities. Provider/Subcontractor shall provide the State and any other legally authorized governmental entity (including without limitation the Centers for Medicare and Medicaid Services ("CMS") and the Office of the Inspector General of the United States Department of Health and Human Services (the "OIG")), or their authorized representatives, the right to enter and/or inspect Provider/Subcontractor's premises, physical facilities, and equipment (or other places where work under the State Contract is performed) at any time to inspect and monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed in connection with the State Contract in accordance with the terms set forth in 42 C.F.R. § 434.6 and in Section 8.1 of Article II of the State Contract. In the event of such inspection/audit, Provider/Subcontractor must, upon request, (i) provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or federal representatives conducting the audit or inspection effort, and (ii) provide reasonable facilities and assistance for the safety and convenience of the persons performing inspections. The foregoing rights to inspect, evaluate, and audit shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. The State or any other legally authorized governmental entity conducting any such inspection (i) shall request access to Provider/Subcontractor in writing, except in cases of suspected fraud and abuse, (ii) shall not unduly interfere with the work being performed by Provider/Subcontractor, and (iii) shall give Provider/Subcontractor ten (10) working days to respond to any audit

findings before the State finalizes those findings, with the State according confidential treatment to all information so obtained. [State Contract, Article II § 8.1; 42 C.F.R. §§ 438.3(h), 438.3(u), 438.230(c)(3)(iii)]

24. Maintenance and Examination of Records; Separate Accounting Records. Provider/Subcontractor shall maintain records, books, documents, papers, and files relating to State's Medicaid managed-care program and to related services and expenditures, including reports to the State and source information used in preparation of those reports, and including without limitation financial statements, records relating to quality of care, and medical records. Provider/Subcontractor shall furthermore maintain accounting records related to the services performed in connection with the State Contract, and shall maintain those records (a) in accordance with generally accepted accounting principles, and (b) in separate books, records, documents, files, or other evidence pertaining to the administrative costs and expenses related to the State Contract to the extent and in such detail as must properly reflect all revenues and all costs of whatever nature for which reimbursement is claimed under the State Contract. Furthermore, Provider/Subcontractor shall provide the State and its authorized agents with prompt, reasonable, and adequate access to any records, books, documents, papers, and files that Provider/Subcontractor maintains regarding the services performed in connection with the State Contract (including the aforementioned accounting records), at no cost to the State or its authorized agents and in a manner that clearly identifies the requested documents as pertaining to the State Contract, all in compliance and accordance with the terms set forth in Section 8.3 of Article II of the State Contract. The State and its authorized agents shall request such access in writing except in cases of suspected fraud and abuse. Provider/Subcontractor shall submit all such records, books, documents, papers, and files to the State or its authorized agents in a manner that maintains the confidentiality of the involved parties (*e.g.*, by blacking out members' and providers' names, as necessary). Provider/Subcontractor shall furthermore comply with the record-retention requirements of 45 C.F.R. §§ 74.21–74.23, and all such records maintained shall be the property of the State, with the exception of medical records and member and provider quality-assurance and quality-improvement records, when confidentiality is protected by applicable law. Provider/Subcontractor shall maintain all of the foregoing records, books, documents, papers, and files (including the aforementioned accounting records and all source records for its data reports) during the entire term of the State Contract, and thereafter during the entire ten (10) year period after the completion date of the State Contract or until final resolution of all pending audits, litigation, claims, negotiations, or other actions involving those records, whichever is later; Provider/Subcontractor must have written policies and procedures in place to govern the storage and maintenance of the foregoing records. Furthermore, upon any non-renewal or termination of the State Contract, Provider/Subcontractor shall turn over to the State and/or its authorized agents, upon that party's request and at no cost to the requesting party, any records (with the exception of patient medical records), books, documents, papers, files, and operational information (including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding subcontractors) that Provider/Subcontractor maintains regarding the services performed in connection with the State Contract, including without limitation all information necessary for the reimbursement of any outstanding Medicaid claims, in order to ensure the orderly transfer of activities under the State Contract and/or to transition data or documentation to the State or to a subsequent MCO or contractor as part of an MCO transition. Provider/Subcontractor shall make all requested medical records available within 10 working days of any State request. [State Contract, Article II §§ 6.14, 6.15, 8.2, 8.3, 8.3.1, 8.3.2, 8.3.3, 8.4; 42 C.F.R. §§ 438.3(h), 438.3(u), 438.230(c)(3)(iii)]

25. Access to Records. Provider/Subcontractor shall provide to the State (a) all information required under the State Contract, including but not limited to the reporting requirements and other information related to Provider/Subcontractor's performance of its obligations under the Agreement; and (b) any information in Provider/Subcontractor's possession sufficient to permit the State to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. If Provider/Subcontractor places any required records in another legal entity's records, such as a hospital, Provider/Subcontractor is responsible for obtaining a copy of these records for use by Company, the State, and/or the State's representatives. Furthermore, Provider/Subcontractor must provide the State and any other legally authorized governmental entity (including without limitation CMS and the OIG), or their authorized representatives, the right to inspect Provider/Subcontractor's records to monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed in connection with the State Contract in accordance with the terms set forth in 42 C.F.R. § 434.6 and in Section 8 of Article II of the State Contract. In the event of such State inspection/audit, Provider/Subcontractor must, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or federal representatives conducting the audit or inspection effort. The foregoing rights to inspect, evaluate, and audit shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

[State Contract, Article II §§ 8.1, 8.4 and Article III § 2.6.3; 42 C.F.R. §§ 438.3(h), 438.3(u), 438.230(c)(3)(iii)]

26. Audit Accounting and Retention of Records. Provider/Subcontractor acknowledges and agrees that the State and other legally authorized governmental agencies, at their option, may conduct (i) an audit of Provider/Subcontractor's operations as they pertain to services and recoveries related to the State Contract, and/or (ii) an audit of, or an inspection of any books or records of, Provider/Subcontractor pertaining to the ability of the Company and/or Provider/Subcontractor to bear the risk of financial losses and services performed or payable amounts under the State Contract. For purposes of any audit, Provider/Subcontractor must provide to the State (including the State Auditor), to the Secretary of the United States Department of Health and Human Services ("HHS"), to any other legally authorized state or federal governmental agency, and/or to any of the foregoing's respective authorized agents, the right to access and examine any materials and information of the Provider/Subcontractor that are relevant to the services performed in connection with the State Contract, at no cost to the requesting party and at any time during the term of the State Contract, and thereafter at any time during the ten (10) year period after the completion date of the State Contract or until final resolution of all pending audit questions and litigation, whichever is later, all in compliance and accordance with the terms set forth in Section 8.3 of Article II of the State Contract. The State and its authorized agents shall request such access in writing except in cases of suspected fraud and abuse. [State Contract, Article II §§ 8.2, 8.3; 42 C.F.R. §§ 438.3(h), 438.3(u), 438.230(c)(3)(iii)]

27. Medical Records. A Provider/Subcontractor that furnishes services to Members shall maintain an enrollee health record for each such Member. Furthermore, if Provider/Subcontractor is the primary care provider (PCP) for a Member, Provider/Subcontractor shall (a) establish and maintain a confidential, centralized medical record that details the care received by that Member, and (b) if the Member changes PCPs, promptly forward to the new PCP all Member medical records or copies thereof to ensure continuity of care. All medical records maintained by Provider/Subcontractor should demonstrate coordination of patient care, including without limitation inclusion in the Member's medical records of any relevant information from referral sources. Provider/Subcontractor shall maintain all medical records in accordance with applicable Company standards, which shall take professional standards into account. These standards include Provider/Subcontractor's duty to maintain Member medical records in a timely, legible, current, detailed, organized, and complete manner to permit quality/utilization review and to disclose the quantity, quality, appropriateness, and timeliness of services provided under the State Contract. Upon request, Provider/Subcontractor shall make its Member health records available and accessible to Company, and to appropriate state and federal authorities and/or their delegates, to permit an assessment of the quality of care and/or an investigation of Member grievances or complaints. [State Contract, Article II § 8.2 and Article III § 5.9]

28. Licensing and Credentialing Requirements; Malpractice Insurance.

a. Provider/Subcontractor shall procure all necessary permits and licenses and abide by all applicable laws, regulations, and ordinances of the United States, the State, and any political subdivision thereof in which work under the Agreement is performed. If Provider/Subcontractor is a home health care provider, Provider/Subcontractor shall maintain a surety bond as specified in Section 1861(o)(7) of the Social Security Act. [State Contract, Article II § 5.14 and Article III §§ 2.1.6, 2.6.3]

b. Provider/Subcontractor shall maintain adequate malpractice coverage, with minimum coverage requirements of $1 million per individual episode and $1 million in the aggregate, to protect against allegations arising out of the rendering of professional services or the alleged failure to render professional services by Provider/Subcontractor and/or its employees. [State Contract, Article III § 2.6.3]

c. Provider/Subcontractor shall comply with all credentialing and recredentialing policies and procedures that Company implements to verify Provider/Subcontractor's credentials, including without limitation by completing a credentialing application in accordance with the State's policies and procedures. Furthermore, Provider/Subcontractor shall comply with all applicable credentialing/recredentialing standards and requirements set forth in the State Contract (and in particular Section 2.1 of Article III thereof), and in applicable federal and State laws, regulations, and written policies, including without limitation W. Va. C.S.R. § 114-53-6. [State Contract, Article III §§ 2.1.4, 2.1.5, 2.1.6]

d. To the extent that Provider/Subcontractor orders, refers, or renders Covered Services, Provider/Subcontractor must enroll as a Medicaid provider with the State, through the State's fiscal agent,

as required by 42 C.F.R. 438.602(b). Provider/Subcontractor acknowledges that (i) enrollment with the State does not obligate Provider/Subcontractor to offer services under the fee-for-service delivery system, and (ii) Company is not required to contract with a provider enrolled with the State if that provider does not meet Company's credentialing or other requirements. [State Contract, Article III §§ 2.1.4]

29. Disclosure of Ownership and Control, Business Transactions, and Interlocking Relationships; Prohibited Affiliations.

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, that is debarred, suspended, or otherwise excluded from participating in federal health care programs (including without limitation Medicare, Medicaid, or Title XX programs), or that is 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, Provider/Subcontractor shall disclose to Company: (i) any ownership and control, relationship, and financial interest information that is required to be disclosed under the State Contract or applicable law (including without limitation names and tax IDs); (ii) any changes to such ownership and control, relationship, and financial interest information within 35 days of such changes; and (iii) information on any healthcare-related criminal convictions of Provider/Subcontractor and/or any director, owner, principal, partner, agent, or managing employee thereof (or other person with an ownership or control interest of 5% or more in the Provider/Subcontractor), to be provided to Company at the time the Agreement is executed, at the time of Provider/Subcontractor's application for or renewal of Medicaid participation, at any time upon request, and immediately upon Provider/Subcontractor's receipt of notice of any such conviction. [State Contract, Article II § 8.6 and Article III § 2.6.3]

b. Upon request by Company, the State, and/or the Secretary of the United States Department of Health and Human Services, or their respective designees, Provider/Subcontractor must submit, within thirty-five (35) days of that request, full and complete information about (i) the ownership of any subcontractor with whom Provider/Subcontractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, and (ii) any significant business transactions between Provider/Subcontractor and any wholly owned supplier, or between the Provider/Subcontractor and any subcontractor thereof, during the 5-year period ending on the date of the request. [42 C.F.R. § 455.105; State Contract, Article II § 8.6 and Article III § 2.6.3]

c. Provider/Subcontractor will not acquire any direct or indirect interest that would conflict with, or compromise in any manner or degree, the performance of its services under the Agreement. Furthermore, Provider/Subcontractor shall not pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value to an employee or agent of the State with the intent to influence work related to the State Contract. Provider/Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to provide to the State or other applicable authorities a copy of a certification attesting to same. [State Contract, Article II §§ 5.18, 5.21 and Article III § 2.6.3]

d. Provider/Subcontractor shall certify upon Company's request that neither Provider/Subcontractor, nor any individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider/Subcontractor, nor any officer, director, principal, partner agent, or managing employee thereof (*i.e.*, general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over that Provider/Subcontractor or who directly or indirectly conducts the day-to-day operation of that Provider/Subcontractor) is an entity or individual: (i) who has been convicted of any offense under section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in section 1128(b)(1)–(3) of the Social Security Act (42 U.S.C. § 1320a-7(b)(1)–(3)); (ii) against whom a civil monetary penalty has been assessed under section 1128A or 1129 of the Social Security Act (42 U.S.C. § 1320a-7a; 42 U.S.C. § 1320a-8); or (iii) who has been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any program under Title XVII, sections 1902(a)(39) and (41) of the Social Security Act, under Title XVIII (Medicare), under Title XIX (Medicaid), under section 4724 of

the Balanced Budget Act, under the provisions of Executive Order 12549, or under any state or federal healthcare program (to comply with this certification, Provider/Subcontractor shall at a minimum review the exclusion lists maintained by the Department of Health and Human Services Office of Inspector General (namely, the HHS OIG List of Excluded Individuals/Entities a/k/a LEIE), by the General Services Administration (namely, the GSA Excluded Persons List System a/k/a EPLS), and by the State). Furthermore, Provider/Subcontractor shall notify Company if any action described in this subparagraph of the West Virginia Medicaid Addendum has been taken or is being taken against any person or entity described above, and shall provide such notice to Company immediately upon Provider/Subcontractor's receipt of notice of such action. [State Contract, Article II § 8.6 and Article III § 2.6.3]

e. For purposes of this paragraph of the West Virginia Medicaid Addendum, the following definitions shall apply:

(i) "Convicted" means that (a) a judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether there is a post-trial motion or an appeal pending or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed; (b) a federal, state, or local court has made a finding of guilt against an individual or entity; (c) a federal, state or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or (d) an individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

(ii) "Disclosing entity" means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

(iii) "Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

(iv) "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity pursuant to 42 C.F.R. § 455.101.

(v) "Person with an ownership or control interest" means a person or corporation that (a) has an ownership interest totaling 5% or more in a disclosing entity; (b) has an indirect ownership interest equal to 5% or more in a disclosing entity; (c) has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity; (d) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity; (e) is an officer or director of a disclosing entity that is organized as a corporation; or (f) is a partner in a disclosing entity that is organized as a partnership.

[42 C.F.R. § 455.101; 42 C.F.R. § 1001.2; State Contract, Article II § 8.6 and Article III § 2.6.3]

30. Marketing Activities. Provider/Subcontractor shall comply with 42 C.F.R. § 438.104 and with "Appendix D: Marketing Policies," the latter of which is attached to and incorporated into the State Contract, with respect to marketing activities and practices, and shall not engage in any direct marketing to Members that is designed to increase enrollment in a particular MCO. Provider/Subcontractor is not prohibited from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance, but shall submit to Company (and, if requested, to the State Insurance Commissioner) for review any marketing materials of Provider/Subcontractor that relate to the State Contract prior to disseminating same. Provider/Subcontractor shall not knowingly use or permit the use of any advertising that is untrue, misleading, or deceptive. [W. Va. Code § 33-25A-14(a); State Contract, Article III §§ 2.6.3, 3.1 and Appendix D]

31. Compliance with Section 6032 of the Deficit Reduction Act of 2005. If Provider/Subcontractor receives annual Medicaid payments of at least $5 million (cumulative, from all sources), then it shall: (a) establish written policies for its employees, managers, officers, contractors, subcontractors, and agents that provide detailed

information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act (codified at 42 U.S.C. § 1396a(a)(68)(A)); (b) include as part of such written policies detailed provisions regarding Provider/Subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse; and (c) include in any employee handbook of Provider/Subcontractor a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act (codified at 42 U.S.C. § 1396a(a)(68)(A)), the rights of employees to be protected as whistleblowers, and Provider/Subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse. [42 U.S.C. § 1396a(a)(68); State Contract, Article III §§ 2.6.3, 8.1]

32. Advance Directives. Provider/Subcontractor shall comply with 42 C.F.R. § 422.128 and the West Virginia Health Care Decisions Act relating to advance directives. [State Contract, Article III §§ 2.6.3, 3.5.4]

33. Compliance with Applicable Laws, Rules, and Policies; Request for Policies.

a. Provider/Subcontractor shall comply with all applicable federal and State laws, regulations, and written policies, including those pertaining to licensing and those affecting the rights of Members, and including without limitation: (i) the federal requirements set forth in Title 45, Part 74 and Title 42, Part 434 the Code of Federal Regulations; (ii) section 504 of the Rehabilitation Act of 1973; (iii) Title IX of the Education Amendments of 1972; (iv) the Age Discrimination Act of 1975; (v) the Americans with Disabilities Act of 1990, as amended; (vi) section 542 of the Public Health Service Act, pertaining to nondiscrimination against substance abusers; (vii) Title 45, Part 46 of the Code of Federal Regulations, pertaining to research involving human subjects; (viii) Title 45, Parts 160 and 164 Subparts A and E of the Code of Federal Regulations, pertaining to privacy and confidentiality; (ix) Title 42, Parts 434 and 438 of the Code of Federal Regulations, pertaining to managed care; (x) section 29a of the West Virginia Code; (xi) the Copeland Anti-Kickback Act; (xii) the Davis-Bacon Act; (xiii) Contract Work Hours and Safety Standards; (xiv) Right to Inventions Made Under a Contract or Agreement; (xv) the Clean Air Act and the Federal Water Pollution Control Act; (xvi) the Byrd Anti-Lobbying Amendment; (xvii) Debarment and Suspension; (xviii) the Patient Protection and Affordable Care Act (PPACA); (xix) the Health Care and Education Reconciliation Act of 2010 (HCERA); (xx) all applicable federal and State laws, regulations, policies, or reporting requirements needed to comply with the policies and regulations set forth in the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010; (xxii) the Mental Health Parity and Addition Equity Act of 2008 and its respective regulations (including without limitation Parts 438, 440, and 457 of Title 42 of the Code of Federal Regulations); (xxiii) the Assisted Suicide Funding Restriction Act of 1997; and (xxiv) any other pertinent federal, State or local laws, regulations, or policies. Provider/Subcontractor shall furthermore comply with all requirements and regulations pertaining to: (i) copyrights, data, and reporting and patent rights under any contract involving research, developmental, experimental, or demonstration work with respect to any discovery or invention which arises or is developed in the course of the State Contract; (ii) applicable standards, orders, or requirements under section 306 of the Clean Air Act (42 U.S.C. § 1857(h)), section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 C.F.R. Part 15); and (iii) energy efficiency, which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (P.L. 94-165). [State Contract, Article II §§ 4.11, 5.14 and Article III § 3.7]

b. Company shall make available to Provider/Subcontractor within 20 business days of receipt of a request, reasonable access either electronically or otherwise, to all the policies that are applicable to Provider/Subcontractor or to particular health care services identified by Provider/Subcontractor. In the event the provision of the entire policy would violate any applicable copyright law, Company may instead comply by timely delivering to Provider/Subcontractor a clear explanation of the policy as it applies to Provider/Subcontractor and to any health care services identified by Provider. [W. Va. Code § 33-45-2(a)(5)]

34. Non-Discrimination. Provider/Subcontractor shall comply with all federal and State laws relating to non-discrimination, including but not limited to: (a) Title VI of the Civil Rights Act of 1964, (42 U.S.C. § 2000d *et seq.*) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15; (b) section 504 of the Rehabilitation Act of 1973 (29

U.S.C. § 794); (c) the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 *et seq.*); (d) the Age Discrimination Act of 1975 (42 U.S.C. §§ 6101–6107); (e) Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681–1688); (f) the Food Stamp Act of 1977 (7 U.S.C. § 200 *et seq.*); (g) Executive Order 11246 and its implementing regulations at 41 C.F.R. Part 60; (h) Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16; and (i) the Immigration Reform and Control Act of 1986 (8 U.S.C. § 1101 *et seq.*). Furthermore, Provider/Subcontractor may not discriminate in enrollment, delivery of health care, or any other activity against Members on the basis of health status, conditions of or type of enrollment in the geographic areas within the State's Medicaid managed-care program, or need for health care services. [State Contract, Article II § 5.15 and Article III § 3.7]

35. Eligibility for Federal Agreements and Grants. Provider/Subcontractor shall comply with any applicable federal requirements and assurances relating to eligibility for federal agreements and grants, as set forth in federal Office of Management and Budget (OMB) Standard Form 424B and in 45 C.F.R. Part 76. [State Contract, Article II § 5.16 and Article III § 2.6.3]

36. Lobbying. Provider/Subcontractor, as provided by 31 U.S.C. § 1352 and 45 C.F.R. § 93.100 *et seq.*, will not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. Provider/Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to provide to the State or other applicable authorities a copy of a certification attesting to same, including without limitation any disclosure form as provided in 45 C.F.R. § 93.110 and Appendix B to 45 C.F.R. Part 93, if any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the State Contract. [State Contract, Article II § 5.17]

37. State's Data Files. Provider/Subcontractor shall establish and maintain at all times reasonable safeguards against the destruction, loss, or alteration of the State's data and any other data in the possession of Provider/Subcontractor necessary to the performance of operations under the State Contract. [State Contract, Article II § 5.19]

38. Disclosure of Legal Proceedings and Related Events. If Provider/Subcontractor, its parent, or one of its affiliates becomes a party to any litigation, investigation, or transaction that may reasonably be considered to have a material impact on Provider/Subcontractor's ability to perform under the Agreement, Provider/Subcontractor shall immediately notify Company in writing. Furthermore, Provider/Subcontractor shall notify Company in writing within twenty (20) calendar days of becoming aware of any of the following matters involving Provider/Subcontractor, its parent, or one of its affiliates: (a) any whistleblower or *qui tam* actions, complaints, or litigation, (b) any class-action complaints or lawsuits, (c) any legal actions or governmental investigations that allege fraud or the possibility of fraud, (d) any bankruptcy proceedings or petitions in which Provider/Subcontractor, its parent, or one of its affiliates is named as a debtor, (e) any litigation, mediation, or arbitration between Company and Subcontractor, and (f) any criminal actions brought against Provider/Subcontractor, its parent, or one of its affiliates. [State Contract, Article II § 8.7]

39. Member Grievances, Appeals, and Fair Hearings. To the extent applicable, Provider/Subcontractor must comply with all State and federal laws, regulations, and policies governing Member grievance, appeal, and fair-hearing procedures, and with all statutory and regulatory timelines related thereto, including the requirements for both standard and expedited requests. If any grievance, appeal, or fair-hearing request is filed with Provider/Subcontractor, Provider/Subcontractor must immediately forward it to Company. Upon entering into the Agreement, Company shall provide Provider/Subcontractor with the same information pertaining Company's grievance, appeal, and fair-hearing procedures as Company provided to its Members, all as described in Section 3.8 of Article III of the State Contract. [State Contract, Article II § 8.7, Article III § 3.8]

40. Service Authorizations. Provider/Subcontractor shall comply with the prior-authorization requirements and processes set forth in Company's policies and procedures, and to the extent applicable shall have in place, and follow, written policies and procedures for submitting and processing requests for initial and continuing authorizations of services for Members. [42 C.F.R. § 438.210(b)(1); State Contract, Article III § 5.4]

41. Member Materials. If Company delegates to Provider/Subcontractor the preparation and distribution to Members of any written materials relating to the Medicaid program, Provider/Subcontractor shall ensure that: (a) all such written materials, whether in hardcopy or electronic format, are in a manner and format consistent with the requirements of 42 C.F.R. § 438.10, using a font size no smaller than twelve (12) point; (b) all such materials are readable at the sixth (6th) grade level, are easily understood, and are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency; (c) Provider/Subcontractor informs all Members and potential Members that the information is available in alternative formats, including how to access those formats; (d) Provider/Subcontractor establishes a methodology for identifying the prevalent non-English languages spoken by Members and potential Members throughout the State, and makes available written information in each prevalent non-English language free of charge to any Member or potential Member; (e) Provider/Subcontractor makes available auxiliary aids and services, as well as oral interpretation services, free of charge to each Member or potential Member, for all non-English languages spoken by Members or potential Members (not just those that the State has identified as prevalent); (f) Provider/Subcontractor notifies Members or potential Members that oral interpretation is available for any language and that written information is available in prevalent languages and how to access those services, if applicable; (g) Provider/Subcontractor notifies Members or potential Members that information is available in paper form without charge upon request, with such information provided within five (5) business days; (h) Provider/Subcontractor makes electronic information available on a website that is prominent and readily accessible, in an electronic form that can be electronically retained and printed; and (i) all written materials include taglines in the prevalent non-English languages and large print (in a font size no smaller than eighteen (18) point) explaining the availability of written translation or oral interpretation and a toll-free and TYY/TDY telephone number. [42 C.F.R. § 438.10; State Contract, Article III § 3.4]

42. Overpayments. Provider/Subcontractor acknowledges (i) that Company is responsible for the recovery in full of all overpayments, including those due to fraud, waste, and abuse, unless the associated investigation is accepted by the State, in which case Company shall take no action unless notified otherwise by the State; and (ii) that 42 C.F.R. §438.608(d)(2) requires Company to have a mechanism in place for Provider/Subcontractor to identify, report on, and return to Company any overpayment that Provider/Subcontractor has received. As such, Provider/Subcontractor shall promptly advise Company if Provider/Subcontractor has received any overpayment, shall return the full amount of the overpayment to Company within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify Company in writing of the reason for the overpayment. Provider/Subcontractor furthermore acknowledges that any overpayments due to fraud, waste, and abuse that are collected by the State will result in reimbursement to all impacted Medicaid managed-care organizations, and that (i) dollars allocated to the managed-care program will first be determined by comparing claim volume under managed care and fee-for-service Medicaid, (ii) the calculated managed-care dollars will then be divided amongst the impacted managed-care organizations based on their respective claim volume for the time period in question, not to exceed the total amount paid by each managed-care organization to Provider/Subcontractor, and (iii) the amount of money returned will be reduced by the applicable Federal Medical Assistance Percentage, with the remainder of the collected monies to be retained by the State. [42 C.F.R. § 438.608(d)(2); State Contract, Article III §§ 2.6.3, 8.3]

Approved by WV BMS 9/24/18 *& WV OIC* 8/27/18